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ABSTRACT

This monograph is based on experiences of the national Child and Adolescent Service System Program (CASSP) and describes a plan for developing and implementing community based systems of care for children and adolescents with serious emotional disorders and their families. It draws on examples from state mental health plans to illustrate planning approaches to systems change. Stressed is the need for the system of care to be child centered, family focused, and community based. The introduction identifies desirable system components and the requirements of the Mental Health Services Plan and its 1990 Amendments. The first chapter identifies principles of effective planning such as the involvement of key stakeholders. The second chapter provides various state definitions of the target population, information on population size, service requirements, and current system assessment. Specific values and principles of CASSP are identified next. The fourth chapter examines the ways by which various states have addressed goals and objectives including structural change objectives relating to infrastructure, financing, and interagency collaboration. Specific strategies, resources and responsibility centers are identified in the fifth chapter. The last two chapters consider planning and progress reporting format and program evaluation methods. A list of technical assistance materials is appended. Includes 16 references. (DB)

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STATE CHILD MENTAL HEALTH PLANNING

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INTRODUCTION

This monograph describes elements of an effective plan for developing and implementing an organized community-based system of care for children and adolescents with serious emotional disorders and their families. It draws on examples from actual state mental health plans to illustrate useful planning approaches to systems change. The monograph is intended to be helpful to state and local administrators and planners and to state mental health planning councils. It is not meant to be prescriptive, but, rather, to offer a framework for planning for children[1] with examples from existing plans, which states may wish to adapt to their particular circumstances.

Throughout the 1980s, beginning with the publication of *Unclaimed Children* in 1982, there was a steady documentation of the need for improved services for children and adolescents with serious emotional disorders and their families (Knitzer, 1982; Isaacs, 1984; Behar, 1985; Stroul and Friedman, 1986; Saxe, *et al.*, 1986; National Mental Health Association, 1989). The literature of the eighties emphasizes the importance of states and locales having in place a range of community-based services that is organized into a system of care.

Recent work defines a system of care for children and their families as follows:

> A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families.
>
> (Stroul and Friedman, 1986)

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[1]Throughout this report, where the term "children" is used, it refers to both children and adolescents, ages birth through 21. (Section II discusses age as an issue in the definition of the child/adolescent target population.)

The system of care concept embraces certain core values, specifically, that the system must be *child-centered, family-focused* and *community-based,* and it incorporates a range of desirable key service and operational components illustrated by Table A.

TABLE A. COMPONENTS OF THE SYSTEM OF CARE

1. **MENTAL HEALTH SERVICES**

   Nonresidential Services:

   Prevention
   Early Identification & Intervention
   Assessment
   Outpatient Treatment
   Home-Based Services
   Day Treatment
   Emergency Services

   Residential Services:

   Therapeutic Foster Care
   Therapeutic Group Care
   Therapeutic Camp Services
   Independent Living Services
   Residential Treatment Services
   Crisis Residential Services
   Inpatient Hospitalization

2. **SOCIAL SERVICES**

   Protective Services
   Financial Assistance
   Home Aid Services
   Respite Care
   Shelter Services
   Foster Care
   Adoption

3. **EDUCATIONAL SERVICES**

   Assessment & Planning
   Resource Rooms
   Self-Contained Special Education
   Special Schools
   Home-Bound Instruction
   Residential Schools
   Alternative Programs

4. **HEALTH SERVICES**

   Health Education & Prevention
   Screening & Assessment
   Primary Care
   Acute Care
   Long-Term Care

5. **VOCATIONAL SERVICES**

   Career Education
   Vocational Assessment
   Job Survival Skills Training
   Vocational Skills Training
   Work Experiences
   Job Finding, Placement & Retention Services
   Supported Employment

6. **RECREATIONAL SERVICES**

   Relationships with Significant Others
   After School Programs
   Summer Camps
   Special Recreational Projects

7. **OPERATIONAL SERVICES**

   Case Management
   Self-Help & Support Groups
   Advocacy
   Transportation
   Legal Services
   Volunteer Programs

(Stroul and Friedman, 1986)

No single public or private child-serving agency has the financial or technical capacity to provide all components of the system of care on its own. One of the major challenges to states in planning and implementing systems of care for children is the development of the necessary collaborative arrangements among agencies. The interagency process involves a myriad of thorny issues that must be resolved to provide the range of comprehensive services that children with serious emotional problems require.

A baseline policy issue that state mental health agencies must resolve in planning is determining when mental health will assume a lead responsibility and for which population of children, and when mental health will assume a supportive role, as well as the nature of that role. The answers to these basic questions have implications for a range of implementation responsibilities, including financing, staffing, case management, service development and training.

During the 1980s, several national initiatives were launched that encourage and assist state and local jurisdictions to develop systems of care for children with serious emotional disturbance and their families. In 1984, with a mandate and funding from Congress, the National Institute of Mental Health (NIMH) started the Child and Adolescent Service System Program (CASSP), which has provided funds and technical assistance to all fifty states, U.S. territories, and a dozen local jurisdictions to improve services for children. CASSP stresses the development of capacity within the mental health system to serve children, interagency collaboration, the involvement of families and cultural competency. In 1986, Congress enacted Public Law 99-660, the State Comprehensive Mental Health Services Plan Act, which required all states to develop and implement plans to create community-based service systems for persons with serious mental illness, which NIMH interpreted to include both adults and children. In 1987, the Robert Wood Johnson Foundation began a major child mental health system improvement initiative, in which 12 states and cities have been involved. In addition

to these national efforts, a number of states, on their own initiative, began to focus greater attention to this area.

Continuing the momentum begun in the eighties, Public Law 101-639 was enacted in late 1990. Known as the Mental Health Amendments of 1990, P.L. 101-639 amends the State Comprehensive Mental Health Services Plan Act (P.L. 99-660) to *require* that state plans for establishing and implementing organized community-based systems of care specifically address the needs of children with serious emotional disorders. P.L. 99-660, as amended by P.L. 101-639, specifies 12 major requirements that states must meet to comply with the law and avoid reductions in federal block grant funds. NIMH has interpreted these requirements to apply to both adults and children and adolescents. The 12 requirements are:

Requirements of P.L. 99-660 as amended by P.L. 100-690 and P.L. 101-639

1. Establishing and implementing an organized community-based system of care for individuals with serious mental illnesses and children with serious emotional and mental disorders.

2. Specifying quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illnesses residing in the areas to be served under such system.

3. Describing services, available treatment options, and available resources (including Federal, State and local public services and resources, and, to the extent practicable, private services and resources) to be provided for individuals with serious mental illnesses to enable them to gain access to mental health services, including treatment, prevention and rehabilitation services.

4. Describing health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to individuals with serious mental illnesses and children with serious emotional and mental disorders with Federal, State, and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems

under the Education of the Handicapped Act (renamed Individuals with Disabilities Education Act).

5. Describing financial resources and staffing necessary to implement the requirements of the plan.

6. Providing activities to reduce the rate of hospitalization of individuals with serious mental illnesses.

7. Providing case management services for individuals with serious mental illnesses who receive substantial amounts of public funds or services; the term "individual with serious mental illnesses" to be defined under State laws and regulations.

8. Providing for the implementation of the case management requirements in the preceding paragraph in a manner which phases in beginning in fiscal year 1989 and provides for the substantial completion of the phasing in of the provision of such services by the end of fiscal year 1992.

9. Providing for the establishment of and implementation of a program of outreach to, and services for, individuals with serious mental illnesses who are homeless.

10. Describing a system of integrated social, educational, juvenile, substance abuse services which, together with health and mental health services, should be provided in order for children and adolescents with serious emotional and mental disorders to receive care appropriate for their multiple needs, including services to be provided by local school systems under the Education of the Handicapped Act (Individuals with Disabilities Education Act).

Other Requirements:

11. Consulting with representatives of employees of state institutions and public and private nursing homes who care for individuals with serious mental illnesses.

12. Utilizing the State mental health planning council, or establishing a new council with comparable membership requirements to advise, review, monitor, and evaluate all aspects of the development and implementation of the State plan. The comments of the council should be formally transmitted to the Governor prior to the submission of the plan to the Secretary, and the comments should be transmitted to the Secretary of the U.S. Department of Health and Human Services. The State mental health planning council must serve as an advocate, and be composed of residents of the State, including in part, seriously mentally ill

> Individuals who are receiving (or have received) mental health services and family members. Not more than 50% of the council's membership may be State employees or mental health providers.
>
> (National Institute of Mental Health, 1991)

While it is hoped that this monograph will be helpful to states to carry out the mandates of P.L. 99-660 as amended by P.L. 101-639, the monograph is not intended to be prescriptive. Rather, it offers a framework for planning for children, illustrated by practical examples from the states.

The framework provided by the monograph draws on general principles of effective planning. The examples from state plans were culled from a review of 20 state mental health plans. These plans were recommended for review by: individuals with child and adolescent expertise who participated on NIMH State Mental Health Plan Review Committees; staff from the NIMH CASSP and State Mental Health Planning Programs; staff from the CASSP Technical Assistance Center; and, several current and former State Mental Health Representatives for Children and Youth (SMHRCY) members.

It is by no means the author's nor the funder's intention to imply that the monograph incorporates the only effective or even "exemplary" state planning practices. Only constraints of time and funding prevented review of additional state plans and inclusion of more examples. The examples that are used have proved viable in their respective states, and they illustrate the generic planning principles discussed. States must make their own determinations regarding the applicability of the examples to their individual structural and environmental situations.

Some states and locales may find the document useful because they are at the beginning of their planning processes for children, are in search of a framework to use and are interested in having the benefit of other states' experiences. Others, who may

be further along in planning and implementation, may find it helpful for comparative purposes or because they are having to make significant adjustments in current plans in response to fiscal or political changes. The document is meant to provide a technical assistance tool for state and local jurisdictions to utilize as they deem appropriate to their particular circumstances. States may find it a useful companion piece to NIMH's document, *Toward a Model Plan for a Comprehensive, Community-Based Mental Health System,* issued in response to P.L. 99-660 (NIMH, 1987).

The report is organized in the order in which one would approach the development of a plan, beginning with the organization of a planning process and moving to: definition of the target population and needs assessment; articulation of values and a vision; establishment of goals and objectives; specification of strategies, resources and responsibility centers to achieve objectives; and, plan and progress report format. The document concludes with a discussion of mechanisms to evaluate progress.

I. THE PLANNING PROCESS

Effective planning deals with both process and content. Deficiencies in either will hinder implementation.

By *process* is meant a series of actions or operations that lead to an end (in this case, the production of a plan that will drive the development of a community-based system of care for children and adolescents with serious emotional disorders). In planning at the state level, these actions or operations tend to include: the formation and use of planning groups or councils; development of working papers and analyses; conferences and forums; and, information exchange through meetings, written minutes, newsletters, teleconference calls and the like.

Effective planning processes share common elements:

- ***Effective planning processes are staffed.*** At least one staff person is assigned the responsibility to organize and manage the planning process. In the case of state child mental health planning, the accountable individual typically is the CASSP Director or the SMHRCY Representative. In some states, the responsibility falls to a staff person in a centralized planning office. That arrangement tends to work, however, only if the general planning staff person coordinates closely with the child and adolescent program staff (CASSP and SMHRCY), who have substantive knowledge of child mental health issues.

Effective processes are not only staffed, of course, but are staffed well. They are carefully organized and managed. Effective staff anticipate: where the process needs to go and in what time frame; what the milestones are along the way; and, who needs to be involved, in what ways and at what points.

Staff ensure that planning council meetings are organized and accessible to different constituencies. The location and time of meetings may discourage some members from attending or, alternatively, enable them to participate. For example, some meetings may be held in the evenings or on weekends to make it possible for working family members to attend. **Ohio,**[2] for example, held a series of forums around the state on Saturdays to make it easier for families to attend. Some meetings may be held on other child-serving agencies' turf as a gesture toward collaboration and to minimize barriers to other agencies' becoming involved. Staff have the responsibility to see that minutes of meetings are taken and distributed and that key constituencies are informed of upcoming agenda items. Staff might also "assign" specific short-term tasks to individual planning council members and others as a means of developing interest and ownership and of accomplishing more with limited in-house staff resources.

- ***Effective processes involve key stakeholders.*** In child mental health planning, these include: family members; state and local mental health system staff who will be involved in implementation; representatives from other child-serving systems who possess, or represent, sufficient clout in their respective agencies to be helpful in policy formulation and

[2]Unless otherwise indicated, all references to state plans are from 1989 P.L. 99-660 state plan submissions.

implementation; private providers; professional organizations; advocates; representatives from legislative bodies; foundation, United Way or other funding representatives; and, youth themselves. *The identification of who the key stakeholders are is itself an important element of effective planning.* By forcing planners to think through who needs to be involved and why, the process helps to clarify roles and responsibilities for children with emotional disorders.

The involvement and investment of key stakeholders is essential to create a constituency for change, to establish or strengthen relationships needed for implementation, to minimize resistance to change, and to create some measure of control in the unstable political and fiscal environment that characterizes public service delivery. By involving a broad-based constituency, the planning process can help to ensure continuity of support for a plan and help to avoid the need for a new plan every time elected or appointed officials change.

There are a variety of ways to involve key stakeholders. The most obvious, but by no means only, way is on a planning group. P.L. 99-660 mandates use of either the state mental health planning council or a new council "to revise, review, monitor and evaluate all aspects of the development and implementation of the state plan" and "to serve as an advocate." P.L. 99-660 stipulates that membership must include consumers and family members, with no more than 50% of members being state employees and mental health providers. Many states have expanded the membership of their councils specifically to include more child- and adolescent-focused representatives and family members. Others have created child and adolescent subcommittees to inform the deliberations of the state's larger council or have used existing CASSP planning committees in this fashion.

In addition to appointing key stakeholders to ongoing planning groups, states have involved stakeholders in time-limited, usually smaller, work groups charged with analyzing a specific area and completing a single task, such as an assessment of inpatient bed needs. This strategy allows for involvement of stakeholders in appropriate ways, at the same time it provides a focus on areas needing special analysis.

States also have involved stakeholders through periodic regional and state-wide meetings, surveys, newsletters, conferences and, of course, more informal, ongoing communication.

A number of states utilize this variety of strategies, not just their planning councils, to involve stakeholders, including the public at large, in planning and implementation. To return to the example of **Ohio**, the state indicated in its 99-660 Plan that while it "will comply with the requirements of P.L. 99-660 regarding [use of] the mental health council, it [the council] will not be the primary or sole process by which broad-based public participation in planning and implementation efforts will be achieved." Ohio, in fact, has utilized over 50 committees with over 700 members. Some committees are policy oriented (*i.e.,* its Block Grant Advisory Committee); others deal with operational issues. Some have a state-wide focus; others are regional. Some help to develop legislation, rules and budgets. The Ohio Plan notes that this broad participation brings together diverse constituencies in a consensus-building process that facilitates development of shared values and change at many levels.

In addition to its use of multiple committees, as well as its Planning Council, both of which include family members and other child-serving agencies, Ohio utilizes quarterly public forums and a number of

interdepartmental work groups on specific topics requiring joint planning and implementation, such as one on mental health services to youth in the juvenile justice system.

- ***Effective planning for children involves families early in the process and in ways that are meaningful.*** **Virginia** successfully involved families early in its process by joining forces with PACCT (Parents and Children Coping Together), a parent advocacy and support organization already existing in the state. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services collaborated with PACCT to develop the state's proposal to NIMH for a CASSP grant, which resulted in PACCT's obtaining a part-time staff position as part of the state's CASSP program funded by NIMH. PACCT members sit on a number of state planning and policy formulation committees, including the Mental Health Planning Council. PACCT keeps local parent support groups informed of state planning activities through a quarterly newsletter. The state has helped to strengthen PACCT and to facilitate development of over 20 local parent support groups by providing mini-grants to parent groups to help pay for meeting-related costs, such as transportation, child care, refreshments and postage.

- ***Effective planning processes ensure meaningful representation of children and families of color.*** In most state systems, children of color are overrepresented in the most restrictive placements and tend to have limited access to treatment services, even in states with small minority populations as a whole. Effective planning processes recognize this as a fundamental systemic problem and take steps to involve minority groups and families of color early in the process. Several states—for example, **Mississippi** and **Pennsylvania**—formed minority affairs committees or subcommittees of their larger planning councils. In

Alaska, with support from the state through local CASSP grants, Native villagers developed ideas for culturally relevant approaches to care for Alaska Native youth with emotional disturbance, which became an integral part of the state's 99-660 plan.

- ***Effective planning processes for children develop and maintain a multi-agency focus.*** Planning for children recognizes that children and their families generally require the services of more than just the mental health agency. Planning councils include representatives from other child-serving agencies who have sufficient status within their respective agencies to make or at least influence policy decisions. A number of states, such as **Ohio, Virginia, Louisiana** and **Tennessee**, among others, have mandated, through legislation or executive order, interagency planning and problem-solving bodies, whose deliberations become part of the state's 99-660 planning and implementation process.

  Virginia, for example, instituted an interagency budget initiative, involving its child mental health, juvenile justice, child welfare, health, substance abuse, mental retardation and education systems, to plan and fund an Interagency Funds Pool and a Local Interagency Services Project. The Interagency Funds Pool provides financial incentives and technical assistance to localities to start new community-based services for children with serious emotional disturbances. The Local Interagency Services Projects are demonstrations of services planned, funded and operated across local agencies.

- ***Effective planning processes involve local planning, administrative and service entities.*** Depending on the state structure, counties, cities, regions, local service boards and a range of community-based providers

and local parent organizations need to be integrated into the state planning process if the plan is to be meaningful.

Kentucky noted in its 99-660 Plan that, like all other states, it is one of "vast cultural and geographic differences, [which] must be considered for services to be appropriately designed and effectively promoted." To ensure that its plan was responsive to this diversity and to promote local ownership and enthusiasm, Kentucky instituted a local planning initiative to complement state-wide planning. Community mental health services in Kentucky, by statute, are administered by 14 regional community mental health/mental retardation boards, each serving a specified geographic area. The boards are responsible for services to all 120 Kentucky counties. The state provided small grants to each of its 14 regional community mental health/mental retardation boards to initiate and manage a planning process that involved key constituencies, identified issues and strategies consistent with each region's strengths, weaknesses and resources, and developed concrete objectives. The local processes and plans were guided by the draft state plan. The regional plans, once completed, were then incorporated into the state plan and also became the basis for developing budget allocations to the regions.

Pennsylvania has a strong county-administered structure for mental health service delivery for both inpatient and community-based services. State law requires county governments to provide a range of mental health services, which most counties approach through contracts with private service agencies. County programs use coordinated planning guidelines developed jointly by the State Departments of Public Welfare (which houses the state mental health agency), Aging and Health to develop coordinated human services plans. The state adjusted the

timelines of this county-level planning process to ensure that the county plans could become part of the 99-660, as well as state budget development, process.

Vermont, a small state with a centralized administrative structure, put in place 12 Local Interagency Teams around the state, comprised of district child welfare directors, children's coordinators from community mental health centers, local special education administrators, private service providers from the area and parents. The local teams develop individualized cross-agency service plans for multi-problem youth with serious emotional disturbance and work closely with a corresponding State Interagency Team to identify systemic barriers and opportunities. The state team, with ongoing local input and review, coordinates the planning process for children with serious emotional disturbance.

- ***Effective planning processes build on and incorporate related programmatic and planning initiatives in the state.*** The opportunities and issues presented by P.L. 99-660, CASSP, Robert Wood Johnson Child Mental Health Projects, child welfare reform efforts, other NIMH initiatives, such as those funded by the Human Resource Development (HRD) and Mental Health Statistics Information Programs (MHSIP), and other related efforts in the state need to be considered in child mental health planning, as do the state's established budget development and planning cycles. Child mental health plans tend to be strengthened by their integration with existing reform initiatives and state planning cycles.

Pennsylvania, for example, includes a section in its 99-660 plan in which it identifies a number of financial and administrative initiatives in the state, such as its Robert Wood Johnson Foundation Grant, that would be utilized as part of its plan "to establish and support a unified system."

- ***Effective planning processes continually seek ways to build constituencies, interest and investment in the plan.*** Effective processes accomplish constituency-building usually through a combination of strong state agency leadership, talented staff, at least one and usually several active planning council members and parents. Such support is crucial to accomplish implementation of objectives. Strategies may involve: development of multiple committees and task forces, as in **Ohio**; state-wide public hearings, which many states utilize; state-wide dissemination of white papers on different aspects of the plan, as in **Vermont**; use of consultants or representatives from other states to generate interest in a system design concept utilized elsewhere; and, a variety of other strategies.

To state the obvious, planning processes that fail to produce viable plans have characteristics opposite from those just described. They are disorganized. There is no committed, accountable staff person assigned to develop and manage the process. Planning councils do not have the "right" members. For example, other agencies may be represented on the planning council by staff who lack decision-making authority (or access to same). They thus cannot commit their agencies to meaningful participation in plan implementation. Key stakeholders are left out or given only token involvement in the planning process—a common failing with respect to families, minority groups and youth themselves. Participants are not given meaningful roles or assignments. The process is not informed by strategic thinking—*i.e.,* what needs to happen when; who needs to be involved; how can they be engaged; what are the barriers to resolve; what are the opportunities upon which to capitalize. P.L. 99-660 planning is not integrated with existing state planning mandates or with related children's service reform initiatives, such as CASSP.

When a planning process has this array of characteristics, the message a state is giving is that it is not serious about systems change. Participants will lose interest

quickly, and the product typically will end up as a plan that sits on a shelf. Conversely, a planning process which —

- is organized and staffed;
- involves key stakeholders, including families, minority groups and other agencies, in meaningful ways;
- is integrated with local planning processes;
- is coordinated with related reform initiatives; and,
- builds a constituency for system improvement —

is far more likely to yield a plan that is dynamic and capable of sustaining the interest and momentum needed for successful implementation.

II. DEFINITION OF THE TARGET POPULATION AND NEEDS ASSESSMENT

Among the first tasks facing planners are those of determining who the target population is, its size, its needs, and the implications of its size and needs for the types and amounts of services required. Planners then must assess the strengths and weaknesses of the current service system against this needs assessment; *i.e.,* how many children are actually receiving services as compared to the need; what kinds of services are they receiving compared to what they require; who is providing services and at what cost; and, what are the problems, barriers and opportunities, given the needs.

Definition of the Population

Defining the target population, while essential, tends to be problematic. The mental health field is itself not clear about who, precisely, is an "emotionally disturbed" child (Isaacs, 1984). Even if there was a concise, universally acceptable definition, states still must grapple with whether their target populations encompass only *seriously* emotionally disturbed or emotionally disturbed children, and, in addition, those *at risk* (which raises yet another set of definitional issues—*i.e.,* who is "at risk"?). Also, states must decide whether the target group includes all children who meet the agreed upon definition or only those who are poor. (The **Connecticut** adult plan, for example, clearly specifies that its target population is the seriously mentally ill *poor,* which it defines as persons with income that does not exceed 150% of the federal poverty level). There is also the issue of the age range of the target population. Many state juvenile codes apply to children to age 21. The Education for All Handicapped Children Act (P.L. 94-142—now known as the Individuals with Disabilities Education Act) covers children to age 22. Most child welfare statutes cover children only to age 18.

Across the child-serving disciplines and agencies, there is ambiguity and diversity in the definitions used to describe often the same population of children with emotional disorders. The mental health system may label a child "conduct-disordered" whom the education system has described as having a behavioral problem related to a learning disability. The juvenile justice system may label the same child "incorrigible", and the child welfare system considers him abused or neglected. That same youngster might also be a runaway or homeless youth whom the courts call a "status offender"; he may be also a "substance abuser" and at risk for HIV infection. Labels are themselves a problem. They can be stigmatizing, exclude children from services or pigeonhole children into systems where they do not belong.

Complicating the task of defining the target population is that those involved in planning processes bring their own biases and the different mandates, perspectives and agendas of the organizations they represent. Because definitions ultimately lead to determining service responsibility, there is tension between agencies' wanting definitions that protect their turf, and wanting definitions that protect them from acquiring too great a share of the service responsibility.

Other child-serving systems, particularly the juvenile justice and child welfare systems, have criticized mental health agencies for adopting definitions that are too narrow and exclude children involved in other systems. On their part, mental health agencies, with limited resources and often no legislative mandate to serve children, have been concerned about defining their target population too broadly. With encouragement from CASSP, states are trying to re-frame the definition issue as a multi-agency responsibility. Entailed is the identification of a population of children, involved in other systems, for whom the mental health system needs to provide *supportive* services, with other systems having the lead administrative and case management responsibility, and identification of a more seriously disturbed population of children for whom mental health needs to provide the lead role, with other systems providing supportive services.

A number of operational state definitions of target populations share common characteristics. They give priority to the following:

(a) children who have *serious* emotional disturbance (usually characterized by severity and chronicity of functional disabilities);

(b) children who have a DSM III-R diagnosis;

(c) children with multiple problems who are involved with more than one agency; and,

(d) increasingly, states are including some defined group of children who are "at risk" for serious emotional disturbance.

North Carolina, for example, gives priority to: (1) seriously emotionally disturbed children and youth; (2) children and youth with more than one disability; and (3) young children, ages 0-7, with developmental delays, atypical development or at high risk, who can most benefit from early intervention and prevention activities.

Pennsylvania's definition includes children, ages birth to 18 (or to 22 if enrolled in special education), who have a DSM III-R diagnosis, receive services from mental health and one or more agencies, and have been identified by a local interagency team as needing services, as well as children at risk, defined as exhibiting substantial (50% or less of expected age level) delays in psychosocial development. Priority at risk children are those whose parents have a serious mental illness, children who have been physically or sexually abused, those who are drug dependent and those who are homeless.

Virginia's definition also targets both children with serious emotional disturbance and young children who are at risk. It includes children under 18 who have a defined mental health problem that can be diagnosed under DSM III-R and/or all of the following: (1) who exhibit problems which are significantly disabling; (2) have problems which have lasted at least one year's time; (3) have problems which have

become more disabling over time; and, (4) require services by more than one agency. Young children, 0-7, who are at risk include children with environmental and psychological stressors, or predisposing factors. Examples include poverty, premature birth, parental psychopathology, physical or sexual abuse and other maltreatment, teenage parenting and parental divorce.

Mississippi also targets children under 18 with serious emotional disturbance, characterized by significant functional disability, DSM III-R diagnosis, multi-agency need and duration, as well as children at risk. "High risk" is defined as: failure-to-thrive syndrome in infancy; failure to achieve developmental milestones at appropriate stages or in normal time ranges in infancy or early childhood; environmental stresses that precipitate social breakdown, such as divorce, death of a family member, homelessness, parental unemployment, severe deprivation due to poverty and single parenthood in a family; families experiencing drug or alcohol addiction or mental illness; children who have been subject to physical or sexual abuse or neglect; and, children suffering chronic physical illnesses or handicaps.

Alaska's definition identifies "severely emotionally disturbed" as a sub-population within "emotionally disturbed" and "severely mentally ill" as a sub-population within "severely emotionally disturbed". The Alaska 99-660 plan gives the following description:

> Children and adolescents who require mental health services are generally divided in Alaska into 2 categories: emotionally disturbed, and severely emotionally disturbed. The sub-population of children and adolescents who require mental health services are referred to as "emotionally disturbed". Those requiring more intensive services are referred to as "severely emotionally disturbed". A severely emotionally disturbed child or adolescent is one who:
>
> 1. Is under the age of 18, or is under the age of 22 and has been receiving services prior to the age of 18 that must be continued for maximum therapeutic benefits; and

2. Exhibits severe behavioral, emotional, or social disabilities that consequently disrupt the child's or adolescent's academic and developmental progress, family and/or interpersonal relationships, often to the point that the child or adolescent is at risk for out-of-home placement or is placed out-of-home; and

3. Has disabilities that have continued for an extended period of time, or on the basis of specific diagnosis by a qualified mental health professional are judged likely to continue for a year or more; and

4. Has disabilities that cannot be attributed solely to intellectual, physical, or sensory deficits; and

5. Frequently requires intensive well coordinated treatment delivered by an interdisciplinary team involving the family, courts, education, mental health and other family services agencies.

Severely mentally ill children and adolescents are part of the overall group of severely emotionally disturbed children and adolescents. These youth must be diagnosed by a psychiatrist as having a schizophrenic, major affective, or paranoid disorder, or, on the basis of evaluation by a psychiatrist, must be judged likely to exhibit these disorders in the future.

The priorities of service development of mental health services for children and adolescents are as follows:

a.) Severely Emotionally Ill (also referred to as Severely Mentally Ill)
b.) Severely Emotionally Disturbed
c.) Emotionally Disturbed

Some states, such as **Vermont,** have codified their definitions in state law. Within their target definitions, some states also identify special sub-populations. **Ohio,** for example, identifies Appalachian, Amish and hearing impaired children; **Alaska** focuses on Alaska Native youth.

There is no one "correct" definition. Each state must decide for itself, but it must make a decision if realistic planning is to proceed.

Size of the Population

Once the planning process has defined the target population, it can turn its attention to conducting a needs assessment. Needs assessment concerns itself both with determining the size of the population and with determining its requirements for well being—*i.e.,* how many children need services and what, ideally, do they need?

To determine the size of the target population, planners need to answer two key questions: one is how many children within the target definition need services, and the second is how many children who need services will receive them from or with the involvement of the public mental health system. Not all children who need services will receive them from the public mental health system. Some children will access services only from private providers who have no relationship with the public sector; and, some number of children, even in the best of systems, will go unserved, if not by choice, then because resources are limited and there are problems of access, availability, quality and the like. Those involved in state planning processes must decide what targets for the public system are honorable but realistic, achievable but not minimalistic.

The art of estimating how many children with emotional disturbance, or with serious emotional disturbance, need services is at a fairly primitive stage (Kessler, 1988). Research at a national level on child and adolescent needs assessment is a good decade behind its adult counterpart. In particular, there is very little research describing how many children need which services (Pires, 1990).

States have used a number of different approaches to arrive at an aggregate number of children in need of services. These have included: use of national prevalence data; use of expert panels and key informants; field surveys; analysis of utilization data; application of social indicators that correlate to a need for services; and, typically, a combination of these. There are advantages and disadvantages to

all. Direct methods, such as field surveys, take time and money, but may give a more accurate estimate than indirect methods, such as use of national prevalence data, which may not be applicable to a particular state. On the other hand, direct methods may be more subjective and, thus, *less* accurate than data that has achieved credibility at a national level. Analysis of utilization data (*i.e.,* numbers of children actually using services) to estimate need for services is especially problematic. At best, utilization data measures demand for services, not need; and, demand, or the extent to which people use services, is skewed by such factors as access, quality, affordability, appropriateness, stigma associated with services and administrative barriers. A family of color, for example, may be very disinclined to use services that are not culturally relevant.

In the children's world, utilization data is rendered even more questionable by the fact that it is often of poor quality. Data systems in state mental health agencies have tended to be very adult-oriented; NIMH's Mental Health Statistics Information Program (MHSIP) has been almost entirely adult-focused. Also, there are few cross-agency data systems at the state level that track children involved in more than one system. A handful of states, such as **Ohio,** have begun to develop cross-agency management information systems, and the Robert Wood Johnson Foundation Child Mental Health Initiative has made this area a priority. However, the "state of the art" presently is in its infancy. As a result, it is difficult for state planners to obtain unduplicated counts of children using services, to know if more than one child in the same family are receiving services, to know which other agencies may be providing services to a child also involved in the mental health system and the like. Data on children using *private* services is even more difficult to obtain.

Some state Certificate of Need processes (which approve applications for new health care facilities) rely on utilization data. They assume that heavy utilization correlates to a high need for services and low utilization to a low need. However, heavy utilization—for example, of inpatient beds—may be due to a lack of other

alternatives; low utilization may be caused by a host of factors, such as location and quality. Reimbursement policies are a critical factor affecting utilization because they create incentives—or disincentives—to use certain services. Many insurance policies, for example, cover inpatient care but not community-based services.

Planning processes often spend inordinate amounts of time and energy defining and counting children. It is essential in planning to do both, and, indeed, P.L. 99-660 requires that state plans specify quantitative targets. However, the degree of refinement is far less important than achieving consensus on targets that are realistic and sound. As one of the authors of the Congressional Office of Technology Assessment report on child mental health services noted:

> Precision does not matter ... because so few of those who need treatment actually receive treatment. In practical terms, it does not matter whether there are 5% who are seriously disturbed (by whatever definition you use) or whether that is 8%. We are so far from providing appropriate treatment that it will be 20 or 30 years (at the present rate) before such information is useful.
>
> (Saxe, 1988)

Just as states have utilized a variety of approaches to determine the gross size of the target population, they have relied on several rationales for determining how many children will receive services from the public mental health system (either in a lead responsibility or supportive services role). This target is, of course, the more important one for resource allocation and system implementation decisions. States that have conducted only an overall needs assessment without establishing a target for the public system will be unable to determine the "size" of the system needed—*i.e.*, the number of service components, staff and dollars required. Those states that have established public sector targets have done so generally through a negotiated process with those involved in the planning process. Negotiations take into account the current capacity of the system compared to the need, and may also consider standards set by other states.

North Carolina, like a number of states, used national prevalence data to determine the size of the population in need of services. It adopted the prevalence rate of 11.8% provided by Gould, Wunsch-Hitzig and Dohrenwend (1981) to determine the overall number of children in need of services, and the rate of 5% of the population provided by Knitzer (1982) to determine the number with *serious* emotional disturbance. However, North Carolina established 2½% of the child population, not 11.8% or 5%, as the target for the public system to serve. North Carolina notes in its plan:

> Although the projected target of 2½% of the population is indeed conservative, it represents substantial and manageable expansion of existing services over the next 8-10 years; and these figures have become the basis for the implementation of the child mental health plan.

Vermont conducted its own statewide needs assessment, utilizing surveys to providers and parents, to arrive at an estimate that 5% of its child population is severely emotionally disturbed. However, Vermont established 2%, not 5%, as the target to be served by the public system. Like North Carolina, Vermont felt that this was a more realistic, though still ambitious, goal given the current capacity of its system.

Maine used a combination of national prevalence data and data from three state interagency pilot projects serving children with emotional disturbance to determine that 5.4% of its child population has serious emotional disturbance. Citing the experience of North Carolina, Maine adopted as its planning target 2% of the population, not 5.4%. Using its 2% target, Maine then estimated the number of children to be served in each of its six regions, and, using data from its pilot projects, broke those numbers down into diagnostic categories. For example, in Maine's Region I, the state estimates that 345 children (or 2% of the child population in the region) will require mental health services from the public system over the course of a year, 177 (or 1%) at a point in time. Of these 354 children, Maine estimates, based on the profiles of children served

in its pilot projects, that 141 can be expected to have attention deficit disorders, 54 major depressive disorders, 7 schizophrenia, etc. The type of approach utilized by Maine breaks large, unwieldy statewide numbers and profiles into manageable snapshots by region, county, local service board, etc.[3]

Service Requirements

Estimates of the aggregate number of children in a state who need mental health services, even when broken down by county, region or other local entity, and even when further refined to a public sector target number, do not indicate, of course, what the services are that those children require or how much of each type of service is needed.

To determine what array of services is needed and how they should be organized into a system, states again have relied both on national research and literature, as well as on state-specific parent and provider surveys and expert panels. The majority of 99-660 plans draw on CASSP materials to describe desirable services and their organization. Many plans also identify requirements specific to characteristics of the population in the state. **Alaska**, for example, described the need for villages to develop their own culturally relevant approaches to care for Alaska Native youth, as opposed to having "solutions" imposed from the outside. **Kentucky** described a critical need for training and education related to community-based services, based on the results of a needs assessment conducted by its Child Mental Health Bureau that surveyed CMHCs, schools, child welfare staff and other public and private child-serving agencies.

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[3]It also should be noted, however, that projecting the number of children by diagnostic category does not translate necessarily to a projection of service slot needs, since diagnostic categories do not provide information related to a child's functional abilities.

Determining how much of each type of service is needed has been far more problematic for states than describing service requirements in general. Few resources have existed at the national level that describe approaches to estimate the size of service components, number of staff, dollars and other resources required. Behar, Holland and Macbeth (1987) describe a method for estimating the relative proportion of each type of service to an entire continuum based on the Willie M.[4] experience in **North Carolina**. Friedman (1987) developed estimates of service capacity in a balanced system of care, based on extrapolations from the Behar, *et al.* methodology and on data from several communities in **Florida**. Most recently, Pires (1990) described an approach used by the **District of Columbia**, adapted from a method developed by the South Carolina Developmental Disabilities Council, that estimates the number of children needing each of the following types of services: outpatient; therapeutic nursery; psychoeducational and day treatment; therapeutic foster care; therapeutic group homes; in-home crisis services; supervised independent living; residential treatment; acute inpatient; and, case management. The D.C. approach also estimates the number of staff, slots (or beds) and dollars needed by component and for the system as a whole.

The approaches described by Behar, *et al.*, Friedman and Pires are all component-oriented; that is, they address the size requirements of specific program components, such as the number of day treatment slots or inpatient beds or case management staff, to serve a given number of children expected to need each program. Work also is needed to address capacity issues in the type of individualized care approach represented by the Alaska Youth Initiative and Project Wraparound in Vermont. In this approach, some amount of funding is left "free", not attached to specific program components, so that very individualized (and, usually, time-limited)

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[4]"Willie M." refers to a class action lawsuit, *Willie M., et al. vs. James B. Hunt, Jr., et al.*, filed against the State of North Carolina in 1979 that was the impetus behind the development of a comprehensive, organized system of services in North Carolina for children with serious emotional disorders who are also violent and assaultive.

services can be purchased for a child and family, such as a tutor attached to the child's school or a homemaker in the family. There is no method currently for determining how many children need this type of individualized, "wraparound" care or the amount of resources required, although the model itself is receiving increasing attention in the literature (Burchard and Clarke, 1990).

Unless a state knows "how much of what" it needs, it is difficult for it to undertake planned, concrete service system development over time. Very few state plans currently, however, attain this level of specificity.

Current System Assessment

States utilize a variety of aspects of their planning processes to assess the strengths and weaknesses of their current systems for children in view of the need. These include: soliciting the views of planning council members and other "experts" in the state; surveys to parents and providers; conferences and other forums; staff reports; analyses of utilization data and other mental health and cross-agency data; quality assurance committee reports; etc. Generally speaking, the more candid a state plan is about its current system, the more realistic and sound is its plan for system improvement.

The **Pennsylvania** 99-660 plan, for example, includes a section on "Service System Problems" that is both succinct and frank. In a few pages, the plan summarizes problems in the current system, as compared to needs, for children with serious emotional disturbance and for children at risk of developing serious emotional disturbance.

Accurate assessment of current services provides a context for system development and a baseline from which to measure progress. NIMH guidelines for

implementing P.L. 99-660 also stress the importance of states' providing a description and analysis of their current service systems.

The needs assessment process, like that of defining values and philosophy described in the next section, is an early part of the planning process that can serve to bring people together, generate interest and begin to develop consensus about system change objectives.

III. VISION, VALUES AND MISSION

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One of the major achievements of the CASSP initiative has been the emergence of a shared vision that defines the essential values and characteristics of an ideal system of care for children with emotional disturbance. Advocates, mental health professionals, state and local administrators and family support groups have begun to share common ground in endorsing CASSP values that include: an integrated multi-agency system of care, which provides a broad range of treatment options; a partnership between parents and professionals; a preference for home-based and community-based non-residential services; and, culturally competent services that respect racial and ethnic diversity. The literature describes CASSP core values and guiding principles as follows:

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive culturally competent services which are provided without regard to race, religion, national origin, sex, physical disability or other characteristics, and which are sensitive and responsive to cultural differences and special needs.

(Stroul and Friedman, 1986)

The existence of a consensus in the field regarding values does not lessen the importance of states' developing and articulating their own sets of values through their state planning processes. The process of formulating values and a vision provides a unique opportunity to bring together different constituencies, to forge new alliances among them, and to generate a momentum and enthusiasm for systems change.

Most state plans articulate CASSP-like principles, values and system design concepts, and some states have encouraged broad citizen participation in the process of formulating these values. In **Pennsylvania,** for instance, the process of value

definition was a vehicle for expanding and educating a new constituency in support of reforming children's mental health services.

Pennsylvania held a series of regional planning meetings allowing citizens to document the shortcomings of the existing system, to articulate a vision of reform and to define the values that should guide its implementation. Consumers, family members, public officials, union representatives, policy makers, service providers, advocates, clinicians and other stakeholders (including representatives from other child-serving agencies, such as child welfare, education and juvenile justice) participated in the Pennsylvania planning process.

As a result of these meetings, the Pennsylvania Office of Mental Health (OMH) adopted a set of values to guide the process of planning a unified system of mental health services, which has a strong family and consumer orientation and which is both adult- and child-focused. The OMH values assert that both adults and children and their families deserve:

- To participate in choosing the nature and extent of needed resources, participate in services voluntarily whenever possible and in evaluating the quality and effectiveness of those services;
- Access to mental health services or related supports regardless of: age; gender; sexual orientation; cultural, ethnic, or racial membership; place, or lack of residence; legal status; English language competence; and presence of other conditions;
- To have services provided in a manner that is individualized, least intrusive or disruptive and promotes personal growth and development;
- Access to mental health services which includes state mental hospitals in their community;
- The opportunity to have the support and involvement of family and friends;
- Services provided by well trained, competent, compassionate staff;

- Opportunities equivalent to others in the community for: housing or a permanent home; employment; education and/or training; health care; recreation; social supports and friendships; spiritual life; other appropriate assistance and benefits; and

- To [have a system that] recognize[s] consumers, family members and professionals as valuable partners at all levels of the mental health services system.

Once adopted, a set of values becomes a roadmap for guiding the direction of reform, resolving difficult disputes and establishing goals, objectives, timelines and fiscal priorities. Values also shape mission statements. **Alaska,** for example, adopted three core values—normalization, unconditional care and individualized care. These core values underpin the plan's mission statement for children, which reads:

> The mission of the child and adolescent section of this plan is to ensure children and adolescents with serious emotional disturbance and mental illness access to a flexible system of care. The care must be based on the unique individual needs of the child and family. Parents and guardians must be involved cooperatively in program planning and decisions to ensure provision of service in the optimum therapeutic environment in the least restrictive setting possible. Funds should follow the child to services and be combined with funding from other child-serving agencies to allow maximum service development.

Effective state plans explicitly demonstrate a logical connection not only between values and mission, but between values and goals and objectives. The **Indiana** plan, for example, asserts as its "first value" a system of care that is "driven by the needs of youth and their families". Consistent with this primary value, the plan calls for the creation of parent support groups (and the resources to support them) as a first-year objective, indicating that family support is integral to system reform, not an afterthought. The Indiana plan also demonstrates a cause and effect relationship between values and objectives by giving high priority in its objectives to the provision of post-hospital step-down care, enabling children to return to their families after hospital stays that are not prolonged by lack of follow-up services. Similarly, in its statement of

principles, the Indiana plan asserts that "youth with severe emotional disturbance require a variety of services cross cutting agency boundaries." Indiana's needs survey was conducted in a manner that is consistent with this principle. Thirty Interagency Boards, made up of representatives from the major agencies that deliver services to children, participated in the survey; included were education and special education, child welfare, health and mental health (both private physicians and public health officials) and juvenile justice.

Some states espouse particularly precise values that are uniquely derived from the special needs of their children. Returning to the example of **Alaska,** its three core values, together with a principle that "services must be based on ... individual needs, as opposed to attempting to fit the child and family to a pre-existing services model", led directly to the goals, objectives and flexible fiscal policies that shaped the state's unique Alaska Youth Initiative, with its emphasis on home-based "wraparound" services.

Values, principles and mission statements provide the context for development of goals and objectives. Without this context, there is no unifying vision for systems change, and the planning process can deteriorate quickly into wrangling over operational specifics. The process of defining values, which focuses on the ideal and makes no immediate demands for resources, is an important early vehicle for building consensus, for, in effect, "securing investors before any money down is required."

IV. GOALS AND OBJECTIVES

GOALS AND OBJECTIVES OVERVIEW

It is not uncommon for state plans to articulate values and a vision for a system of care for children and then fail to develop goals and objectives that are clearly connected to, and that will operationalize, their values and vision. Even more often, states *are* able to develop goals but not objectives.

Values, mission statements and goals concern themselves with what is desirable. Objectives deal with what is doable (though not minimalistic, since objectives flow from the vision, but, rather, what is ambitiously realistic). It is essential in planning to articulate both a vision and concrete objectives. Conceptualization of the vision or ideal system provides a context to guide operational planning. Plans that launch into operational specifics without having first established this context tend to have objectives that are fragmented. By the same token, development of concrete objectives ties the ideal to reality. Plans that stop at the vision and never establish specific objectives usually end up on shelves. Such plans serve neither as management tools nor agents for systems change; they fail mainly because they lack concrete, meaningful objectives (or because there are serious defects in the planning process as described in Section I).

The establishment of *goals*, while still tending toward the ideal, is the first step in operationalizing more broadly based mission statements and values. Also, the process of developing goals, which, unlike the process of developing objectives, makes no specific demands for dollars, staff, time or other resources, can serve as a means to enlist the support and generate the enthusiasm needed for specifying and implementing objectives. Generally, effective processes attempt to develop consensus around a limited set of critical goals that relate directly to the values and mission.

Virginia's plan provides one example of goal-setting. The Virginia plan articulates four values. In an abbreviated form, they are:

1. The system must be *consumer and family oriented;*
2. The system must be *community centered;*
3. The system must be *accessible, coordinated* and *comprehensive* and *compatible* with diverse cultural and special need groups; and,
4. The system must be of *high quality.*

Virginia's mission statement is based on these values. The mission (again in abbreviated form) is:

- To build a comprehensive network of service components for children with serious emotional disturbance or who are at risk;
- To build a network of outreach to homeless individuals with serious mental illness;
- To develop services that represent a shared vision about the way in which they should be delivered;
- To provide services that recognize the unique potential of each child; and,
- To provide services to children and families that maximize opportunities for involvement and self-determination.

Directly related to its values and mission statement are six **goals**. Again in abbreviated version, they are:

1. To ensure the availability of a *coordinated case management* system through each local service board;
2. To develop *a responsive* service *system* that includes an *array of services;*
3. To expand *early identification and intervention* for children at risk;

4. To promote *interagency coordination* and collaboration;

5. To develop funding incentives to enable localities to *expand the community service system;* and,

6. To *promote the involvement of parents, families, civic and advocacy groups* in policy, system development, public education and in the legislative process.

Having established goals for the system, effective planning processes next tackle what is usually the more difficult task of specifying objectives to operationalize each goal. **Objectives must describe explicitly what is to be done, by when and by whom toward achievement of a goal. Objectives are quantifiable, measurable (that is, they can be evaluated), realistic, feasible, time specific, prioritized, often staged (*i.e.*, short-term, intermediate and long-term), and relevant to the goals.**

Returning to the example of Virginia, the state plan describes several objectives under each of the six system goals. To illustrate:

Goal One (Case Management)

Objective 1. By FY 1994, each Community Service Board (CSB) will have in place seven full-time child/adolescent trained case managers for seriously emotionally disturbed children and their families per 10,000 child population.

Goal Two (Responsive System with an Array of Services)

Objective 1. By FY 1992, each CSB with a child population of 10,000 and above will have established at least one of the less restrictive, non-traditional services: intensive in-home services; day treatment/education; individualized residential treatment. For CSBs with a child population below 10,000, a plan for the development of at least one of the less restrictive, non-traditional services by FY 92-94 will be in place.

Goal Three (Early Identification)

> Objective 1. By FY 91, each CSB will be participating in at least one interagency activity related to early identification and intervention services for children, ages 0 to 7, which is outlined in the mandated local interagency agreement. Such activities may be through P.L. 99-457; P.L. 100-297; Head Start; etc.

Under each objective, Virginia describes strategies for achieving objectives. The importance of identifying strategies, which first entails understanding what resources, responsibility centers and sequence of events are required to achieve objectives, is discussed in Section V.

STRUCTURAL CHANGE OBJECTIVES

Based on a review of existing state plans and feedback from state plan reviewers, it would appear that it is difficult for states to develop concrete objectives that clearly specify what is to be done, by whom and by when. An even greater challenge, however, is for states to articulate objectives that actually address systemic, or structural, change. Yet, the basic purpose of P.L. 99-660 (as well as CASSP) *is* systemic change.

Structural change objectives concern themselves with those aspects of current operating procedures (usually the most entrenched) that seem most irrational in light of the values, vision and goals of the plan. In the world of public child mental health service delivery, the "irrational" may be that —

- There is no mandate, or designated funding, for the public mental health system to provide community-based children's services;
- Three-quarters of state child mental health dollars are spent on inpatient care;

- Block grant funds for community-based services are allocated to community mental health centers whose services are not responsive to the needs of children with serious emotional disturbance and their families.

- Minority children are overrepresented in inpatient and residential treatment facilities and underrepresented in services provided by CMHCs;

- Administrators with operational and budgetary control over child mental health services at state and local levels are predominantly adult-focused;

- Parents are viewed by clinicians in the system as "part of the problem";

- The child mental health, child welfare, juvenile justice, education, health and substance abuse systems do not collaborate, though they share caseloads;

- There is no requirement or mechanism to collect child-specific utilization data or to develop child-specific standards either within the mental health system or across child-serving agencies;

- The state mental health agency has a policy of reducing inpatient beds, but the state's Certificate of Need process, managed by another department, keeps approving applications for new beds from for-profit providers;

- Most of the state's population of children in out-of-state residential care have serious emotional disturbance, but the mental health system plays no role in the placement of these children (or prevention of placement), monitoring of their care or development of after-care plans.

The above list is by no means exhaustive, nor does it characterize all states. However, it is illustrative of the kinds of structural, or systemic, problems often cited in state plans. These kinds of structural problems are the most difficult but most important to tackle if change is to become "institutionalized"—that is, if it is to endure.

It requires a fair amount of rigor and tenacity in the planning process to identify and achieve consensus on structural change objectives. For example, an objective calling upon the CASSP program to fund a newsletter for parents would not generate the same degree of anxiety within the system as an objective requiring all state hospitals and local service boards to include parents as equal participants on treatment planning and discharge planning teams. Though both objectives may be worthwhile, it is the latter objective (if implemented with the same degree of rigor and tenacity) that would lead to more enduring systemic change.

Similarly, an objective to create a bureau of child and adolescent services within a state mental health agency, and to give it operational and budgetary authority for children's services, will lead to more enduring systemic change than an objective to create a special assistant for children's services with no operational authority. An objective to change a state's Medicaid plan from the clinic to the rehabilitation services option, so that a range of community-based services for children can be covered, will create greater structural change than an objective to create a one-time set-aside of state monies to fund local community-based services demonstrations (though, again, both objectives may be worthwhile). An objective to enact legislation to mandate state and local interagency policy formulation and individual services planning teams will produce greater systemic change than an objective calling for quarterly meetings of child-serving agency representatives.

Systemic or structural change requires leadership and a constituency directed toward meaningful objectives. The following subsections describe structural change objectives, across a number of key areas affecting children's services, taken from existing state plans.

A. Objectives Related to Infrastructure

By "infrastructure" is meant the underlying foundation or basic framework of the mental health system. Knitzer found in 1982 that the infrastructure of most state mental health systems was heavily adult-oriented. Central operations, such as data systems, planning offices, training, budget development, standard-setting, Human Resource Development (HRD) and basic organizational structures were predominantly focused on adult services (Knitzer, 1982). Regional or area offices, local service boards and CMHCs tended to have similar adult-oriented structures and staff. Since Knitzer's findings, a number of state plans have focused objectives on changing the infrastructures of their systems to make them more "child-friendly" and to give children's issues greater visibility and clout within the system.

In its 1986 plan, for example, the **District of Columbia** included an objective to create within its Commission on Mental Health a Child and Youth Services Administration with operational and budgetary authority for the entire continuum of child mental health services, inpatient through community-based services.

In its 99-660 plan, **North Carolina** included a number of objectives related to infrastructure. The state included an objective to develop, over a five-year period, synchronicity between the mental health system's data system and those of the other major child-serving systems. It included an objective for its central Office of Human Resource Development to develop a six-year plan to support the child mental health system, including pre-service education, recruitment, distribution, utilization, career systems, orientation, on-the-job training, continuing education, retention, certification, credentialing and licensing.

Early in its process, **Virginia** focused on an objective to change the structure and mandate of its local service boards by requiring that each designate a child and adolescent services director.

Ohio included an objective in its 99-660 plan to augment the capacity of its central research and evaluation office to evaluate and conduct research in the children's area. It also included an objective to ensure that the planning process conducted by mental health boards at the community level focus discretely on children's needs and integrate a specific children's plan into the larger community plan.

Pennsylvania's 99-660 plan includes an objective to create a CASSP project in all 45 county (or joinder) programs, which have the authority in Pennsylvania to administer core mental health services. By instituting CASSP projects in each county, the state seeks to ensure that its counties have the capacity to participate in and manage the coordinated system of care promoted by CASSP. Pennsylvania also has an objective to require that all Office of Mental Health policy bulletins regarding admission to and discharge from state hospitals and continuity of care agreements between state mental hospitals and county programs contain specific requirements applicable and appropriate to children and families.

B. Objectives Related to Financing Structures

Funding structures in a state often are themselves irrational, given the values, vision and goals of the state's plan. For example, a goal may be the development of an array of accessible community-based services, but the state's Medicaid plan is structured in such a way that only inpatient care for children and clinic-based outpatient services are covered. A value may be that services should be provided in the least restrictive, most normalized setting, yet Title IV-E (child welfare) or P.L. 94-142 (education) monies are used to pay for out-of-state residential care for children with serious emotional disturbance instead of in-home crisis and respite services or community-based day treatment. Recognizing that financing plays a major role in influencing the types of services provided and who receives them, many states have focused on objectives to change financing structures as a way to support the

development of a community-based system of care. In addition, P.L. 99-660 requires that state plans describe "financial resources ... necessary to implement the requirements of the plan."

A number of state plans include objectives to change state Medicaid plans. For example, **Mississippi** (along with other states) had an early objective to change the state Medicaid plan to cover case management and day treatment as eligible services. Some states, such as **Oregon**, focused on objectives to switch from the clinic to the rehabilitation services option to cover a broader range of community services. A few states, such as **Pennsylvania**, have included objectives in their 99-660 plans to broaden the scope of services and the size of the population covered by EPSDT (Early Periodic Screening, Diagnosis and Treatment) under Medicaid.

Another financing system change is to alter the allocation of federal block grant monies. **Kentucky**, for example, included an objective to divert a larger share of block grant dollars to children's services.

Some states have established objectives to change the way in which the state allocates state dollars to the regions, counties or local service boards, to give local entities greater fiscal incentives and control to shift dollars from inpatient to community-based services or to target services to those most in need. **North Carolina**, for example, has an objective, known as the Pioneer Project, to restructure the funding of services delivered by its area mental health authorities to: target services to those with *serious* mental illness or emotional disturbance (and, in the case of children, also to those at risk of serious emotional disturbance, reflecting an important early intervention goal of the North Carolina child plan); and, to encourage local authorities to develop and provide the array of services called for in a system of care. The Pioneer Project establishes a purchase of services model of funding in which state dollars would be earned by area programs based on the delivery of specific types of services to the designated target population. The North Carolina plan stages implementation of this

objective over several years, including: in the first year, enactment of legislation to ratify the project, as well as initial developmental work between the state and five pilot sites; in the second year, development of policies, rules and procedures and start-up of the five pilot sites; beginning of evaluation in the third year; and, expansion to all other area programs staged over a remaining five-year period.

Pennsylvania has an objective to change its county funding and reimbursement structures to create a unified system at the county level. Counties would be given control over both community mental health and state hospital dollars, as well as Medicaid expenditures. Counties thus would have the option of using dollars currently spent on state hospital care to develop community-based alternatives to hospitalization. Counties would control client flow by acting as gatekeepers to the unified system.

North Carolina and **Pennsylvania** also have objectives in their 99-660 plans to implement "managed care" demonstrations as a means of controlling dollars spent on restrictive placements and encouraging spending on alternative (and less expensive) community-based services. North Carolina's objective is part of its Fort Bragg demonstration project, and Pennsylvania's is part of its Robert Wood Johnson Child Mental Health Project in Delaware County.

Blending funding across child-serving agencies, or utilizing the funding streams of other agencies, such as Title IV-E (child welfare) or P.L. 94-142 (education) dollars, is another objective states have targeted to make financing mechanisms more conducive to supporting community-based services for children with serious emotional disturbance. The **Alaska** 99-660 plan, for example, has an objective to create a "new" pot of flexible funding, made up of mental health, education and social services dollars, to support individualized assistance and case management, also called "wraparound" services, for children with serious emotional disturbance. **Ohio** has an objective to utilize Title IV-E (child welfare) dollars for family preservation services to prevent out-of-

home placement of children with serious emotional disturbance. The **District of Columbia** 1986 plan included an objective to use education dollars to pay for the education components in its inpatient, residential treatment, day treatment and therapeutic pre-school components.

Some states, such as **Kentucky**, have objectives to increase state appropriations for child mental health services by getting legislation enacted to create new service mandates for children with serious emotional disturbance. The Kentucky objective was to enact legislation to provide intensive family-based services or "wraparound services".

A number of states, such as **Oregon**, have objectives to mandate that private insurance plans cover mental health services or, if already covered, include a wider array of community-based services.

Several states, such as **Pennsylvania**, have objectives to increase access to income supports and entitlements, such as Supplemental Security Income (SSI) and Title IV-A (emergency assistance) dollars, which can help low-income children and families offset the cost of care. Such objectives may involve placing benefit acquisition specialists at local service levels, training for case managers, families and others on entitlement criteria and application procedures and improved coordination between the state mental health and public assistance agencies.

C. Objectives Related to Interagency Collaboration

For over 20 years, the literature on children's services has described the fragmentation and needless duplication that characterize children's service delivery due to the categorical nature of child-serving systems and their lack of coordination. The literature also has described the need for holistic, comprehensive services for children

and families with multiple problems that can only be achieved by effective interagency collaboration. This is a basic premise of the CASSP program and is certainly implied by P.L. 99-660 in its requirement (#4) that state plans describe "health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to ... children with serious emotional and mental disorders ...", and in its requirement (#10) that state plans describe "a system of integrated social, educational, juvenile, substance abuse services which, together with health and mental health services, should be provided in order for children and adolescents with serious emotional and mental disorders to receive care appropriate for their multiple needs...."

As noted in the Introduction, no one child-serving agency has either the technical or financial capacity to provide the array of services spelled out in the CASSP system of care concept or by 99-660. Effective planning processes seek to identify cross-system collaboration objectives that are meaningful and enduring. These may include collaboration dealing with policy and budget formulation, program development and service provision, financing, case management, individual treatment planning, research, evaluation and data systems. Their common feature is the objective of breaking down categorical approaches to service delivery to create more holistic systems of care.

The process of identifying meaningful interagency objectives serves to help clarify where the mental health system needs to assume a lead responsibility, with other agencies providing supportive services, and where the mental health system needs to play the supportive role with other agencies taking the lead.

A number of states, such as **Ohio, Kentucky** and **Vermont**, focused on objectives to enact legislation to create state and local level interagency teams with responsibility for joint policy development and problem resolution and interagency case

planning and service provision for children with multiple problems, including serious emotional disturbance.

The **Virginia** 99-660 plan has a number of specific objectives that flow from its expressly stated goal "to promote interagency coordination and collaboration in the planning, funding and delivery of services [with] ongoing mechanisms for addressing policy, fiscal, administrative, programmatic and data collection issues." Virginia's objectives include: establishing common definitions of "serious emotional disturbance" and of "high risk" across child-serving systems; establishing common entry processes at the local level for coordination of services; and, creation of an Interagency Funds Pool to assist localities to keep children in their own homes.

The **North Carolina** 99-660 plan has an objective to share staff, funds and programs across its three divisions of mental health, development disabilities and substance abuse, including development of common screening instruments, single points of entry at local service levels and decategorization of services.

The **Pennsylvania** 99-660 plan identifies objectives for the mental health system to provide supportive services for children predominantly involved in other systems. For example, it has an objective to increase mental health's support for the Student Assistance Program, which is a school-based program to identify, intervene with and refer students at risk for chemical abuse, suicide or other major mental health problems. There is also an objective to include a mental health assessment in EPSDT examinations provided to children who have been physically or sexually abused.

D. Objectives Related to Development of Community-Based Services

Both CASSP and 99-660 include as a fundamental tenet the development of an organized community-based system of care for children with serious emotional

disturbance. States have focused on a variety of objectives to establish community-based systems of care.

Some states, such as **New Jersey**, which enacted legislation prohibiting state hospitalization of children under age 11, have objectives to close state hospital beds and divert inpatient dollars to community-based services. (Indeed, another requirement of P.L. 99-660 is that state plans "provide activities to reduce the rate of hospitalization".) Other states, such as **North Carolina** and **Kansas**, have objectives to reduce inappropriate hospitalization and ensure children are referred to community-based services by creating "single portals of entry" at the local level. As described by the North Carolina 99-660 plan, "The single portal of entry concept ... ensures proper screening at the area level prior to referral to the hospital." The single portal of entry concept often is accompanied, as in North Carolina, by objectives to give local offices greater financial incentive to divert children from hospital to community-based care. The **Kansas** plan focused on an objective to enact state legislation to: (a) mandate 100% screening of all admissions to state hospitals by community mental health centers and assign the "gatekeeping" responsibility and authority to CMHCs; (b) mandate joint discharge planning between state hospitals and CMHCs; (c) establish a free flow of clinical information between state hospitals and CMHCs and mutual clinic staff privileges; and (d) provide additional community-based services in a phased approach.

Another approach is for states to establish objectives that prioritize development of community-based services by local, regional or area agencies. The **Virginia** plan, for example, has an objective that, by FY 1992, each local service board will have established at least one of the less restrictive, non-traditional services, including intensive in-home services, day treatment and individualized residential treatment. The **Ohio** plan included an objective to expand development of "core" community-based services, including day treatment, therapeutic foster care, home-based services and case management, by earmarking funds for these services to its local service boards.

A number of states, such as **Ohio**, have objectives to use CASSP and state dollars to develop local demonstrations of community-based services as a means of "testing" and marketing new system concepts. These local demonstrations are evaluated and the outcomes brought to the attention of state legislators for consideration for broader implementation. Other states, such as **Virginia** and **Alaska**, as discussed in the financing section, have objectives to blend funds from several child-serving agencies to develop community-based services.

E. Objectives Related to Case Management

Closely related to the development of community-based services in state plans are objectives to develop case management services. P.L. 99-660 requires that state plans include provision of case management services "for individuals with serious mental illnesses who receive substantial amounts of public funds or services." CASSP and other reform initiatives for children recognize case management as a critical mechanism to create continuity and coordination of care for children and families who are involved with several service components and agencies and whose needs change over time.

P.L. 99-660 requires states to have begun phasing in provision of case management services to targeted populations by 1989 and "substantial completion of the phasing in of the provisions of such services by the end of fiscal year 1992." The process of developing case management objectives that are implementable requires states to define carefully both who is to receive case management and what those services are. In addition, changes to state Medicaid plans to cover case management services necessitates definition of both the service and the eligible target population.

Many state plans have objectives that describe *intensive* case management services, which are targeted to those who are most seriously ill. **Pennsylvania**, for

example, has an objective in its 99-660 plan to establish intensive case management for children with serious emotional disturbance as a new service under the state's Mental Health Act. This will make intensive case management a mandated service at the county level. Pennsylvania describes its intensive case management as follows:

> A key component to creating a unified, comprehensive services system for adults, adolescents and children is the ability to link consumers and family members with the appropriate mental health services and supportive resources. The redesign of the case management service to provide the linking and supportive services necessary to negotiate the variety of mental health and supportive resource systems and options is a priority initiative within the system redesign activities.
>
> Many clients, particularly people with a severe mental illness and the families of children with serious emotional disturbances, need a significant amount of assistance in utilizing mental health services appropriately as well as addressing basic living needs such as housing, food, medical, recreation, education and employment.
>
> The Department will be working with county programs, universities and the State's Mental Health Training Institutes (Western Psychiatric Institute and Clinic, Eastern Pennsylvania Psychiatric Institute, Central Pennsylvania Psychiatric Institute) to prepare the necessary numbers of individuals to meet the projected staffing need from the ranks of college graduates, workers from other fields, consumers and family members.
>
> Intensive case management services are intended to assist people with mental illness and children and adolescents with serious emotional disturbance to gain access to needed medical, social, educational, vocational and other services. Activities undertaken by staff providing intensive case management services include: linking with services; monitoring of service delivery; outreach; assessment and service planning; problem resolution; informal support network building; and use of community resources.
>
> Case management services for children and adolescents with severe emotional disturbance and their families are defined and operated within the contextual framework of the Pennsylvania CASSP initiative and the principles developed by the Pennsylvania CASSP Interdepartmental Children's Policy Committee. In addition, three unique issues are recognized in the provision of case management services to children and adolescents:
>
> 1. Accommodations must be made to the rapid growth and development of children and adolescents and the vast differences among them throughout their developmental stages;

2. Children and adolescents are dependent upon their parents and family members for basic food, shelter, clothing, security and nurturance; therefore, parents are partners in the treatment and coordination of services. They are not merely spectators or recipients of recommendations, but are essential members of the team; and,

3. The broad cross-system distribution of services (at least nine state funded systems in Pennsylvania), which provide care for children and adolescents with emotional disturbance require a tremendous amount of professional commitment to networking and interagency collaboration to provide coordinated care and treatment for the children and their families.

Each client will receive case management services as frequently as needed and for the duration of time needed. Frequency of service contact may be as often as daily and will be at least weekly. Caseload sizes are limited to a maximum of 30 clients for each full-time equivalent case management staff person.

Staff assigned to perform intensive case management activities must be organized as a separate and identifiable unit in order to avoid conflict of interest and keep intensive case management records noting activities, contacts and progress. Intensive case management units will establish formal and informal links with service providers as needed.

The Department intends to continue the expansion of intensive case management services through both the re-direction of existing mental health dollars at the local level and allocation of new state mental health dollars.

Some states, such as **Virginia**, have objectives to develop curricula in intensive case management and to train local service board staff. As discussed in the financing section, many state plans include objectives to change state Medicaid plans to cover case management services.

F. Objectives Related to Family Involvement

Researchers and practitioners in the field of children's mental health agree that quality services and successful treatment for children with emotional disturbance must involve the family.

Almost every state plan cites the creation of a "child-centered system of care" as both a core value and a primary goal. As Stroul and Friedman note in the 1986 "System of Care" monograph:

> Implicit in this value is a commitment to serving the child in the context of the family. In most cases, parents are the primary care-givers for severely emotionally disturbed children, and the system of care should support and assist parents in this role as well as involve parents in all decisions regarding service delivery. The system of care should also have a strong and explicit commitment to preserve the integrity of the family unit whenever possible. In many cases, intensive services involving the child and family can minimize the need for residential treatment. *Thus, a child-centered system of care is also a family-focused system of care.* (Emphasis added.)
>
> (Stroul and Friedman, 1986)

National family advocacy groups, such as Families As Allies, the Federation of Families for Children's Mental Health and NAMI-CAN (National Alliance for the Mentally Ill–Child and Adolescent Network), describe a family-focused system of care as one that provides: an array of comprehensive services that strengthens and supports family life; the encouragement and authority for families to plan and evaluate their child's treatment; and, meaningful opportunities to participate in state-level policy planning and service reform (Friesen and Koroloff, 1990). A number of states have established concrete objectives to operationalize family-focused values and goals.

Virginia's plan lists several objectives intended to strengthen existing parents' organizations so that they have the ability and the power to become enduring, effective, informed and visible advocacy entities in the state. For example, the plan has objectives to give PACCT (Parents and Children Coping Together) a key role in state-level planning, policy formation and legislative education through participation on key committees, such as the Virginia Treatment Center for Children Planning Council, the State Consortium on Child Mental Health and the Mental Health Advisory Committee.

The plan provides a number of objectives to ensure that there is an effective voice for children in the state. One objective, for instance, obligates the Department of Mental Health to assist PACCT, the Mental Health Association, the Virginia Association for the Mentally Ill and the League of Women Voters in launching a collaborative advocacy campaign to educate legislators and the general public about children's mental health service needs.

The **Vermont** plan envisions an equally substantive role for parents in its reorganization of children's services. In its first year, for example, the Vermont plan had an objective to create 12 Local Interagency Teams charged with reviewing, developing and settling disputes concerning treatment plans for hard-to-place youth. The parents of the child under discussion sit on the Interagency Team, along with an additional parent-member who is a permanent Team member. Other permanent members include representatives from the key agencies that provide services to children, such as the special education administrator and the coordinator for children's services at the community mental health center. In addition to reviewing individual treatment plans, the Teams also develop priorities for local services needs.

Parents also participate on an Advisory Board that the Vermont plan has established to advise the Secretary of Human Services and the Commissioners of Mental Health, Education and Rehabilitative Services on matters relating to children who have severe emotional disturbance. Five parents of children with severe emotional disturbance sit on the Board along with five advocates and five providers. The Board reviews and evaluates current budgets and makes recommendations to the Commissioners for new service initiatives.

In **Pennsylvania**, objectives have focused on having parents of hospitalized children sit on a special advisory committee that is charged with conducting assessments of all patients affected by the closing of a state hospital. Along with

hospital staff, independent psychiatrists and private agency staff, families of patients are accorded a role in the decisions that surround the disposition of individual patients.

G. Objectives Related to Cultural Competency

Although most children's mental health plans affirm their commitment to providing services without regard to race, religion or national origin, few states have developed specific objectives to ensure that children of color have access to culturally competent services. The need to focus on objectives for achieving cultural competency has intensified in many states where the number of minority children has grown but the percentage of those children that receive services has not increased at the same rate. At the same time, children of color who <u>are</u> in state care frequently are found in the most restrictive, out-of-home settings, suggesting that the relatively few minority children who are receiving services may not be receiving appropriate care.

In response to this challenge, the State of **Alaska**, with its large population of Native Alaska children living in remote villages far from urban treatment centers, developed specific objectives to make its system more responsive. Alaska planners did not attempt to impose their own solutions on the Native population, but, rather, collaborated with village leaders in an interactive planning process to identify culturally relevant service objectives. A major objective was the Alaska Youth Initiative (AYI). AYI empowers local teams, unconstrained by traditional solutions, to devise their own village-based treatment plans, which are then reviewed by state mental health planners. These treatment plans are based on an "environmental assessment" that takes into account not only the child's strengths and weaknesses, but also the resources and stresses in the environment. Flexible funding mechanisms enable the state to underwrite the cost of village-based "wraparound" services that allow treatment to take place within the Native cultural community. AYI seeks to achieve cultural competency

and to avoid "placement" in service components out of state or otherwise far from villages, except as a last resort.

The **Ohio** plan also incorporates objectives to focus on minority concerns. Objectives require that local mental health boards must address minority issues in the plans that the boards submit to the state along with their requests for funding. The local plan must include a section specifying strategies and objectives for improving the quality of culturally competent treatment.

Mississippi established objectives to train additional mental health staff in cultural competency, in an effort to increase the utilization of mental health services by minority populations. To accomplish this objective, the plan mandates the Division of Community Services, Children and Youth Services, and the Division of Human Resources to collaborate with the University of Mississippi on the development of a training program to "address the Southern culture in general and minority populations of this culture in particular." The effectiveness of the new curriculum will be evaluated in a study to determine if, as a result of increased cultural competence, there has been an increase in the number of minority children and youth who utilize mental health services.

In addition to its training efforts, Mississippi included objectives to establish a Minority Affairs Advisory Committee within its Division of Human Resources to monitor statewide progress in achieving cultural competence. Mississippi's Division of Children and Youth Services also has initiated a Minority Mental Health Planning Committee with particular interest in improving services, advocacy efforts and support networks for African Americans, Vietnamese and Native American children and their families.

V. STRATEGIES, RESOURCES & RESPONSIBILITY CENTERS

Effective planning processes do not stop with the establishment of concrete objectives that address structural change and specify who is to do what by when. They also identify the resources, and strategies for accessing or developing the resources, necessary to achieve objectives. P.L. 99-660 also requires that state plans "describe financial resources and staffing necessary to implement the requirements of the plan."

The term "resources" includes not only funding, but all means necessary, useful or helpful to attain a desired end. Resources may encompass funding, staff, families, facilities, equipment, information, expertise, advocates and other kinds of support. The process of identifying strategies to accomplish objectives requires that those involved in the planning process conceptualize what resources are needed, in what sequence and over what time period. Strategies to access or develop these resources may involve financing, staffing, legislation, training, service demonstrations, interagency negotiations, advocacy and the like.

As noted in Section IV, the **Virginia** plan includes several strategies under each of its objectives to achieve its six major goals. To illustrate, the following relates to Goal One of the Virginia plan:

> **Goal One:** To ensure the availability of a comprehensive, coordinated case management system through each Community Services Board which is responsive to the complex service needs of seriously emotionally disturbed children and their families.
>
> **Objective 1.1** By FY 1994, each Community Services Board will have in place seven full-time child/adolescent trained case managers for seriously emotionally disturbed children and their families per 10,000 child population.

Strategies:

a. DMHMRSAS will promote the priority nature of case management through the Regional Child and Adolescent Services Meetings by distributing information and/or making presentations on a quarterly basis. (FY 90 and 91)

b. Virginia CASSP Director will assist advocacy/constituency groups in targeting case management through their local education efforts related to CSB service development. (FY 90 and FY 92)

c. DMHMRSAS will target Community Services Boards that are in the top one-third of admissions to state hospital programs to ensure that an adequate case management system is in place by FY 1994. (FY 93)

d. DMHMRSAS will develop, revise and distribute Departmental policies which reflect the priority status of case management services. (FY 90)

e. VTCC will contract for the development of a training curriculum in case management services for seriously emotionally disturbed children, to be utilized statewide. (FY 90)

f. VTCC will develop a certification program for case managers, to be accessed statewide. (FY 91)

g. Through the CASSP grant, DMHMRSAS will provide training in case management to the CSBs who are developing case management services in FY 90 through new initiative funds. (FY 90)

The strategies delineated in the Virginia plan also clearly identify what planners call "responsibility centers", that is, the entities responsible for implementing given strategies.

The **Connecticut** *adult* plan provides, in a somewhat different format, another example of strategies and responsibility centers, attached to clearly stated objectives, that flow from articulated goals. To illustrate, the following is from Connecticut's 99-660 plan:

Goal I: Provide a Comprehensive Array of Community Mental Health Services

Objective: The Department will increase service provision in emergency-crisis and case management services in SFY 1990. This will be accomplished by completing the implementation of 3 crisis resolution centers and 2 assertive community treatment programs and developing a third assertive community treatment program.

Criterion: Actual program expansion will be monitored through the Quarterly Services Activity Report.

Objective: The Department will develop and submit requests for program expansion funds for presentation by the Governor to the Connecticut General Assembly as part of a proposed state budget. Expansion funding will be requested for forensic services (inpatient, community support, staffing), outpatient services (outpatient services for Southeast Asian refugees), community support for elderly persons (residential, case management). In addition, funding is being requested for 5 service system development projects. Each region will use these projects to augment the current array of available services. The requested service system expansion will be implemented in SFY 1991, if funded.

Criterion: The Department's program expansion request will be submitted to the Connecticut Office of Policy and Management by 01 October 1989.

Objective: The Department will provide or fund case management services to 100% of all patients discharged from one of the major state hospitals (Connecticut Valley Hospital), as part of a pilot case management program.

Criterion: Case management service provision will be assessed through a comprehensive evaluation of the case management pilot program. The evaluation will also examine the adequacy/appropriateness of discharge and community treatment plans, the level and intensity of services provided, personal satisfaction, and individual level of functioning. The next evaluation report is due in January 1990, and subsequent reports annually thereafter.

The Connecticut adult plan takes the additional step of developing performance criteria for each objective so that progress can be measured against an agreed upon standard. The importance of having the capability to evaluate progress is discussed in Section VI.

Obviously, *financing and staffing strategies* are particularly critical to achieving objectives. Given that, it is surprising the number of 99-660 plans that do not identify the dollars needed, nor the adequacy of the work force, to implement objectives. Effective state plans link objectives to dollar and manpower requirements, making it possible for those in the state, as well as outside reviewers, to gauge the feasibility of objectives and to monitor progress.

The **Maine** 99-660 plan, drawing on the methodology described by Behar, Holland and Macbeth (1987), links the number of children needing services by region to the quantity and cost of services required. The following chart from the Maine plan, which focuses on services for the 0-5 age group, illustrates the state's approach —

AGE 0-5 PROGRAM COMPONENTS
ANNUAL FUNDING PROJECTIONS BY REGION

COMPONENT	COST PER SERVICE BLOCK	REG. I AROOSTOOK .76 (1)	REG. II E. MAINE 2.03	REG. III KEN./SOM. 1.41	REG. IV TRI-CTY. 1.58	REV. V/C CUMBERLAND 1.81	REG. V/Y YORK 1.46	REG. VI B-B/M-C 1.41	STATEWIDE COST ANNUALLY
Non-Residential:									
Parent Support									
Self-Help Groups	$ 8,480	$ 6,445	$ 17,215	$ 11,957	$ 13,399	$ 15,349	$ 12,381	$ 11,957	$ 88,704
Parent-to-Parent	36,812	27,977	74,729	51,905	58,163	66,630	53,746	51,905	385,056
Ident. & Assessment	22,250	16,910	45,168	31,373	35,156	40,273	32,486	31,373	232,740
Case Management	75,301	57,228	152,860	106,174	118,975	136,294	109,939	106,174	737,644
Transportation	23,282	17,695	47,263	32,828	36,786	42,141	33,992	32,828	243,533
Child & Family Support	119,887	91,114	243,371	169,041	189,422	216,996	175,036	169,041	1,254,022
Crisis Intervention	1,731	1,316	3,514	2,441	2,735	3,133	2,527	2,441	18,106
Autism Services	63,866	48,538	129,648	90,051	100,908	115,598	93,244	90,051	668,039
Respite Care	13,685	10,401	27,781	19,296	21,622	24,770	19,980	19,296	143,146
Therapy									
MH Clinic-Based	53,146	40,391	107,886	74,935	83,970	96,194	77,593	74,935	555,904
MH In-Home Therapy	212,057	161,163	430,475	299,000	335,049	383,822	309,603	299,000	2,218,112
PT/OT/ST	8,914	6,775	18,095	12,569	14,084	16,134	13,014	12,569	93,240
Home-Based Family Services	149,695	113,768	303,880	211,070	236,518	270,948	218,554	211,070	1,565,807
Center-Based Services									
Infant/Toddler Groups	148,775	113,069	302,013	209,772	235,064	269,282	217,211	209,772	1,556,184
Preschool Groups	200,200	152,152	406,405	282,282	316,316	362,361	292,292	282,282	2,094,089
Residential:									
Respite/Crisis	36,102	27,437	73,286	50,903	57,040	65,344	52,708	50,903	377,622
Spec. Foster Homes	24,454	18,585	49,642	34,481	38,638	44,262	35,703	34,481	255,792
	$1,198,637	$910,964	$2,433,232	$1,690,078	$1,893,846	$2,169,532	$1,750,009	$1,690,078	$12,537,759

[1]Units of 10,000 population (age Birth-5) per region. This is the number of "service blocks" required per region to meet the treatment needs of special needs youth children within this general population of 10,000.

Maine also developed staffing projections, as illustrated by the following chart, again referring to services for the 0-5 age group —

AGE 0-5 PROGRAM COMPONENTS
TEN-YEAR ANNUAL PROGRAM DEVELOPMENT TARGETS

	FY 88 (CURRENT)			PROJECTED FY 92 (40%)			PROJECTED FY 94 (60%)			PROJECTED FY 98 (100%)		
COMPONENT	NUMBER OF COMPONENT	SIZE OF SERVED[1]		NUMBER OF COMPONENT	SIZE OF SERVED[1]		NUMBER OF COMPONENT	SIZE OF SERVED[1]		NUMBER OF COMPONENT	SIZE OF SERVED[1]	
Non-Residential:	1,303[2]	NA										
Parent Support												
Self-Help Groups	27	1	FTE	84	3	FTE	126	4	FTE	210	7	FTE
Parent-to-Parent	30	1	FTE	84	3	FTE	126	4	FTE	210	7	FTE
Ident. & Assessment	0	0	Teams	NA	1	Teams	NA	2	Teams	NA	3	Teams
Case Management	0	0	FTE	65	6	FTE	97	8	FTE	162	13	FTE
Transportation	180	NA	Funds	242	NA	Funds	362	NA	Funds	604	NA	Funds
Child/Family Support	580	21	FTE	*			*			806	31	FTE
Crisis Intervention	0	0	FTE	0	3	FTE	1	4	FTE	1	7	FTE
Autism Services	45	5	FTE	92	13	FTE	137	18	FTE	229	30	FTE
Respite Care	2	171	Providers	*			*			3	202	Providers
Therapy												
MH Clinic-Based	60	2	FTE	81	3	FTE	121	4	FTE	202	7	FTE
MH In-Home Therapy				322	15	FTE	484	20	FTE	806	33	FTE
PT/OT/ST				NA	NA	Funds	NA	NA	Funds	NA	NA	Funds
Home-Based Fam. Serv.	9	1.5	Teams	16	3	Teams	25	4	Teams	41	7	Teams
Center-Based Services												
Infant/Toddler Grps	6	1	Groups	188	36	Groups	283	47	Groups	471	79	Groups
Preschool Groups	329	41	Groups	*			*			335	42	Groups
Residential:												
Respite/Crisis	0	0	Beds	3	4	Beds	4	6	Beds	7	10	Beds
Spec. Foster Homes	2	2	Homes	6	10	Homes	10	13	Homes	16	22	Homes

[1]At any one time. This * program capacity.
[2]Current contracting system reports these children as receiving "early intervention" services (therapies, family support, screening, evaluation and assessment, play groups and home teaching services).

The **Alaska** 99-660 plan projects the number of children needing particular types of services, develops a unit cost for each service and, by multiplying the number of children by the unit cost, arrives at a projected total cost for service enhancements. Below is an illustration of Alaska's approach, using day treatment as the example —

Estimated Need for Day Treatment Services

- Currently, fewer than 75 children and adolescents who need these services have access to them.
- It is estimated that the overall number of children and adolescents needing day treatment services is 1,290 (at the lowest prevalence estimates).
- Using a standard utilization rate of 30%, the number of children and adolescents who would use day treatment services is 387 (using the lowest prevalence estimates).
- Each child or adolescent would receive approximately 250 days of service per year.
- The average cost for day treatment services are $50 per day, based on existing state rates.

Estimated Cost

One client costs $50 per day x 250 = $12,500.
Costs for 387 clients = $12,500 x 387 = $4,837,500.

In FY89, approximately 45 clients had access to these services, for a total cost of approximately $562,500.

Three-Year Goals

Year	Additional Clients to be Served	Additional Cost Per Year
FY 90*	30*	$375,000*
FY 91	30	$375,000
FY 92	30	$375,000

Note: By Alaska statute, the priority population for services is the severely mentally ill. FY 90 funding will ensure that all SMI children and adolescents that need services of this type will have them available.
*No new funding received in FY 90.

Some states, such as **Mississippi**, include separate sections in their 99-660 plans establishing a series of manpower, or Human Resource Development (HRD), objectives necessary to achieve the systems change objectives in their plans. For example, Mississippi has an objective to enhance its capacity to recruit qualified minority personnel by establishing a linkage program with historically Black universities and colleges in the state. This objective is closely related to objectives in both the adult and children's plans to develop culturally relevant services and to improve access to treatment for children and families of color.

The process of conceptualizing what resources are required, and identifying strategies for accessing/developing them, forces those involved in the planning process to consider and gauge the feasibility of implementing objectives. The question of feasibility must take into account financial, staffing and other operational realities, programmatic and technical capacity and political concerns. The process of weighing feasibility is essential to the development of meaningful objectives. It also serves as a way of educating the various constituencies involved in planning as to the realities informing, constraining and aiding systems change.

Conceptualizing strategies and weighing their feasibility leads planners to prioritize objectives and establish contingency plans. Having contingency strategies is essential in an unstable fiscal and political environment. Contingencies help to ensure that progress will continue even if initial objectives cannot be attained. This momentum, however incremental, is vital for system improvement, for implementation of P.L. 99-660 and for sustaining the interest of those involved in the planning process and other key stakeholders. States that have identified contingency strategies are able to submit 99-660 progress reports that indicate movement in spite of barriers to initial plan objectives. The following section addresses the format of plans and 99-660 progress reports.

VI. PLAN AND PROGRESS REPORT FORMAT

Effective planning processes produce plans which not only incorporate meaningful content—*i.e.,* a vision, goals, concrete objectives and specific strategies—but which also are readable and accessible to stakeholders in the system. Effective plans must serve as legible roadmaps to systems change for a diversity of audiences with varying sophistication about mental health issues. Thus, the format of plans needs to be clear, logical and concise. It is surprising the number of state plans, however, that are difficult to read and comprehend. They are far too long, overwhelm the reader with minutiae or fail to include critical data, skip from one topic to another without suggesting approaches to resolving issues raised and, in general, make reading them a laborious endeavor.

There is no one correct format for state plans, of course. Several states with very different formats have readable and accessible plans. The **Pennsylvania** 99-660 plan, for example, integrates the adult and children's plans without sacrificing a discrete child focus. In the first section of the Pennsylvania plan, there is an integrated (but appropriate to each population) adult/child mission statement and set of values. In the second section, there are descriptions of both target populations and estimates of need for each. The third section discusses the unmet needs of both adults and children, and the fourth describes current program and service initiatives on behalf of both. Sections five and six discuss goals, objectives and strategies for both adults and children. The last section describes the planning process. It is probably more difficult (and certainly not necessary) for states that are just embarking on planning for children to integrate their child and adult plans, however.

Other states, such as **Maine**, have separate children's plans or, like **Mississippi**, a separate children's section in their overall plan. Where there are separate children's plans or sections, it is important that states address system-wide issues, such as HRD

or data issues, with both populations in mind, as Mississippi did in including system-wide HRD goals and objectives that are relevant to both populations.

NIMH has required states not only to develop plans under P.L. 99-660, but progress reports as well. NIMH has asked states to document progress toward implementing objectives in a format that describes objectives and progress under each of the 12 requirements of 99-660 (for both adults and children). The challenge this poses for child mental health planners is that there is a great deal of overlap among the 12 requirements. For example, interagency objectives and progress toward achieving them could as easily "fit" under Requirement #4 as Requirement #10; objectives and progress related to development of community-based services could go under Requirement #1, or #3, or #4. (These requirements are summarized in the Introduction to this monograph.)

Secondly, because Congress tacked children's services on to P.L. 99-660, which remains adult-oriented in language if not intent, a number of the requirements sound more applicable to adults with serious mental illness than to children and their families. To illustrate, Requirement #6 requires states to "provide activities to reduce the rate of hospitalization of individuals with serious mental illness." In some states, this might be an appropriate objective for children. In other states, however, there is a far greater problem with residential placements, particularly in out-of-state facilities. In some states, there may be too few inpatient beds accessible to poor and uninsured children and too many for-profit beds accessible only to those with the ability to pay. In this example of Requirement #6, as well as other requirements that seem not quite child-specific, it would make sense for states to explain in a paragraph or two *their* interpretation of how the requirement applies to children and describe their objectives and progress in the context of that interpretation.

The following is a suggestion for how states might approach description of child-related objectives (and progress) under each of the 12 requirements of 99-660.

It is not meant to be prescriptive, but to stimulate thinking about approaches to responding to 99-660 reporting requirements. The following was developed by Beth Stroul in conjunction with a group of individuals affiliated with the CASSP Technical Assistance Center at Georgetown University, who have been providing technical assistance to the states regarding P.L. 99-660. To reiterate, these suggestions do not represent either NIMH or P.L. 99-660 mandates. They simply pose ideas for organizing child-related objectives under the 12 requirements of 99-660.

SUGGESTIONS FOR DESCRIBING CHILD-RELATED OBJECTIVES AND PROGRESS UNDER THE 12 REQUIREMENTS OF P.L. 99-660

Requirement 1: Establishing and implementing an organized community-based system of care for individuals with serious mental illnesses and children with serious emotional and mental disorders.

Discuss progress toward conceptualizing and implementing a community-based system of care and achieving any state level accomplishments that promote system development.

Possibly include objectives and outcomes related to:

- Definition of vision of system of care that state is working toward
- Achievements that support the development of systems of care, including:

  Legislation
  Regulation, standards, guidelines
  Budgetary, financing policies
  Planning activities (state, regional, local)
  Establishment of children as priority
  Establishment of new types of services

- Other structural, organizational, system level accomplishments that contribute to support system of care development.

Requirement 2: Specifying quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illnesses residing in the areas to be served under such system.

Discuss progress toward developing and meeting specific <u>quantitative targets</u> relative to serving children and the development of the children's service system.

Possibly include objectives and outcomes related to:

- Definition of target population for services
- Basic system data (on the target population and service system)
- Completion of needs assessment regarding target population and systems, *i.e.*

  Number of children in target population
  Percentage of target population currently served
  Number of children in target population being served by various child serving systems
  Number of children in state hospitals
  Number of children in out-of-state placements across systems
  Number of children served by community mental health programs (broken down by specific services if possible)
  Number of "slots"/capacity in various components of system of care

- Specification of targets and showing progress toward these, including:

  Increasing numbers of children served
  Increasing proportion of identified/target population served
  Increasing numbers served in various system of care components
  Increasing number of slots/capacity in various system components
  Reducing utilization of out-of-state placements, hospitalizations and residential treatment across child-serving systems
  Increasing utilization of alternatives to hospitalization and residential treatment

- Steps to develop an approach to "sizing" the system of care; *i.e.*, determining needed capacity within various system components
- Steps to improve management information system to provide useful data regarding children for planning, research and evaluation purposes

Requirement 3: Describing services, available treatment options and available resources (including Federal, State and local public services and resources, and, to the extent practicable, private services and resources) to be provided for individuals with serious mental illnesses to enable them to gain access to mental health services, including treatment, prevention and rehabilitation services.

Discuss progress toward improving <u>access</u> to services for children and families.

Possibly include objectives and outcomes related to:

- Outreach efforts
- Efforts to reach minority populations
- Efforts to implement/expand screening and assessment services
- Efforts to expand crisis services
- Efforts to create single entry points for services
- Early identification and intervention efforts
- Efforts to identify and reach high risk populations
- Efforts to reach special populations
- Interagency efforts to enhance access to services
- Efforts to empower families

Requirement 4: Describing health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to individuals and children with serious emotional and mental disorders with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Education of the Handicapped Act (renamed Individuals with Disabilities Education Act).

Discuss progress toward improving the <u>array of services</u> in the system of care for children.

Possibly include objectives and outcomes related to:

- Improving the availability of mental health services, including:

<u>Nonresidential Services</u>	<u>Residential Services</u>
Prevention	Therapeutic foster care
Early intervention	Therapeutic group care
Assessment	Therapeutic camp services
Outpatient treatment	Independent living services
Home-based services	Residential treatment services
Day treatment	Crisis residential services
Emergency services	Inpatient hospitalization
Case management	
Respite care	

- Assessment of service gaps
- Establishing priorities for service development
- Increasing available "slots"/capacity in these service components
- Progress toward service development goals
- Progress toward improving/expanding the array of other services (beyond mental health) needed by children and families

Requirement 5: Describing financial resources and staffing necessary to implement the requirements of the plan.

Discuss progress toward improving financial and human resources.

Possibly include objectives and outcomes related to:

- Financing:

  Increased resources for children's mental health
  Increased proportion of mental health resources for children as compared to adults
  New funds accessed from federal, state, local and private sources
  Maximizing Medicaid mechanisms and service options
  Use of Title IV-E
  Use of blended funding across child-serving agencies
  Decategorization of funding
  Redirected funds from institutional to community-based services
  Implementation of creative financing strategies
  Improved access to benefits and entitlements, such as SSI

- Human Resource Development:

  Efforts to increase availability of staff qualified for community-based services
  Efforts to collaborate with universities or colleges around pre-service education
  Provision of training and technical assistance to community agencies and providers (*e.g.*, conferences, workshops, on-site assistance, etc.)
  Efforts to provide in-service training for professionals in community-based approaches
  Efforts to recruit minority professionals
  Provision of training regarding culturally competent approaches
  Initiatives to involve families in service provision

Requirement 6: Providing activities to reduce the rate of hospitalization of individuals with serious mental illnesses.

Discuss progress toward reducing the rate of inappropriate hospitalization and residential treatment placements for children and adolescents, as well as efforts to improve access to beds for children who are under-served.

Possibly include objectives and outcomes related to reducing rates of inpatient, residential treatment and out-of-state placements:

- Adequacy of inpatient and residential treatment capacity:

  State hospital
  Residential treatment centers
  Community hospitals
  Private hospitals

- Progress toward reducing the number of beds if appropriate
- Efforts to reduce rates of hospitalization, residential treatment, out-of-state placement, including:

  Gatekeeping/screening mechanisms
  Influencing Certificate of Need processes
  Managed care programs
  Initiatives to return children from out-of-state placements

- Efforts to expand intensive community-based services as alternatives to hospitalization
- Efforts to expand crisis residential services in non-hospital settings

Requirement 7: Providing case management services for individuals with serious mental illnesses who receive substantial amounts of public funds or services; the term "individual with serious mental illnesses" to be defined under State laws and regulations.

Requirement 8: Providing for the implementation of the case management requirements in the preceding paragraph in a manner which phases in beginning in fiscal year 1989 and provides for the substantial completion of the phasing in of the provision of such services by the end of fiscal year 1992.

Discuss progress toward implementation of <u>case management</u> services.

Possibly include objectives and outcomes related to:

- Definition of population targeted for case management
- Definition of a case management model/approach
- Development of standards for case management appropriate to the defined child population
- Development of funding mechanisms for case management
- Implementation of training for case managers
- Expansion of availability of case management services

Requirement 9: Providing for the establishment and implementation of a program of outreach to, and services for, individuals with serious mental illnesses who are homeless.

Discuss progress toward serving <u>homeless</u> children and adolescents

Possibly include objectives and outcomes related to:

- Definition of homeless children, adolescents and families and of target group
- Outreach efforts to reach these groups
- Funding strategies and resources to serve this population
- Demonstrations or other programs providing mental health and other services to homeless youth
- Efforts to serve runaway and homeless adolescents
- Development of linkages with youth service systems in the state

Requirement 10: Describing a system of integrated social, educational, juvenile, substance abuse services which, together with health and mental health services, should be provided in order for children and adolescents with serious emotional and mental disorders to receive care appropriate to their multiple needs, including services to be provided by local school systems under the Education of the Handicapped Act (renamed Individuals with Disabilities Education Act)

Discuss progress toward development of <u>interagency structures and mechanisms</u> to coordinate the roles and resources of all key child-serving agencies

Possibly include objectives and outcomes related to:

- Interagency entities at state and local levels – roles and accomplishments
- Coordinated planning activities with other systems (*e.g.*, education, child welfare, juvenile justice, substance abuse, health, etc.)
- Coordinated planning with P.L. 99-457 and the early intervention process
- Special efforts to coordinate planning and service delivery with education system (P.L. 94-142)
- Joint funding, service delivery, training, demonstrations with other agencies

Requirement 11: Consulting with representatives of employees of state institutions and public and private nursing homes who care for individuals with serious mental illnesses.

Discuss progress toward <u>consulting with appropriate constituencies</u> for developing systems of care for children.*

Possibly include objectives and outcomes related to:

- Consulting with hospital and residential treatment providers in planning community-based systems
- Consulting with families and family groups
- Involvement of other key constituencies

*Note: Broadening the interpretation of this requirement may provide an opportunity to address family issues and work with other constituencies. In its narrowest sense, however, requirement relates to consulting with employees, and their representatives, of the various institutions specified.

Requirement 12: Utilizing the state mental health planning council, or establishing a new council with comparable membership requirements to advise, review, monitor and evaluate all aspects of the development and implementation of the state plan. The comments of the council should be formally transmitted to the Governor prior to the submission of the plan to the Secretary, and the comments should be transmitted to the Secretary of the U.S. Department of Health and Human Services. The state mental health planning council must serve as an advocate, and be composed of residents of the state, including in part, family members. Not more than 50% of the council's membership will be state employees or mental health providers.

Discuss progress toward <u>involving child mental health representatives and parents</u> on the planning council and in planning activities.

Possibly include objectives and outcomes related to:

- Composition of planning council

  Persons with expertise in children's mental health community-based systems
  Parents of children under age of 18/21
  Representatives of other child-serving agencies

- Separate planning entity for children's services, such as CASSP

  Specific to mental health or broader
  Role of entity
  How it is integrated with planning council

VII. EVALUATION OF PROGRESS

Effective planning processes incorporate a capability to track and monitor progress toward achieving objectives, as well as the quality of progress, against agreed upon performance measures. While this may seem apparent—and is certainly essential for complying with P.L. 99-660 reporting requirements—many state plans, in fact, do not address the issue of how implementation of plan objectives will be evaluated and against what measures.

As noted in the Goals and Objectives Section, meaningful objectives, by definition, can be evaluated. Evaluation serves to alert planners as to where plan revisions are needed, contingencies are called for or changes in the planning process are required. Evaluation also is a vehicle for bringing together planners and implementors—to ensure that the plan is "implementable" but, at the same time, not minimalistic.

Some states, such as **Connecticut** with respect to adult services, have in-house capacity to track and monitor objectives. The Connecticut adult plan includes an entire section on monitoring and evaluation, which the state achieves through a series of management information systems. The MIS systems produce: a Quarterly Service Activity Report that includes performance projections, quality assurance indicators and target population indicators at the community mental health program level by region; a Psychiatric Inpatient Utilization Report; a New Program Development Status Report; and, a Consolidated Financial Status Report that tracks projected and actual expenditures on a monthly basis for mental health facilities and programs.

Other states, such as **Tennessee,** include objectives in their 99-660 plans to develop or improve evaluation systems to track system outcomes, the effectiveness of programs and individual outcomes.

Several states, such as **Pennsylvania,** define outcome measures for each stated objective in their plans. For example, the Pennsylvania plan included an objective to "establish the capacity in every county/joinder to implement and manage the system of care for children and adolescents with emotional disturbance and their families." The outcome measures attached to this objective include:

- Contingent on availability of funds, 45 CASSP Coordinators are hired and ensure the operation of 45 parent support groups (by 6/92);
- Forty-five county annual plans and updates include the system of care description (by 6/92); and,
- Technical assistance/training component for the CASSP County Steering Committee and MH/MR administrators is established (by 9/92).

A number of states, such as **Ohio**, utilize their state planning councils to evaluate progress. Indeed, P.L. 99-660 requires that states utilize their planning councils to "evaluate all aspects of the development and implementation of the state plan." Ohio's planning council has a formal mandate from the state to evaluate implementation and is involved in defining the parameters of the evaluation. The state earmarks dollars specifically for evaluation. The planning council works in conjunction with the state's Office of Program Evaluation and Research, which solicits input from a broader group of stakeholders as well. This input is given to the planning council to assist with its assessment.

Some states, such as **Alaska** and **Vermont**, have formed linkages with universities to evaluate the progress and quality of system change objectives. The Vermont plan described its approach to developing both an Outcome Evaluation Component and a Process Evaluation Component as follows:

Outcome Evaluation Component

Although few people working in human services question the importance of good outcome data, systems change is rarely based on a systematic determination of what happens to the people who receive the services. The outcome evaluation component proposed by DMH will design and pilot test a client outcome evaluation system in Vermont. Basic behavioral indicators (modelled after those in the Alaska Youth Initiative's client outcome monitoring system) will be developed. Consumer satisfaction questionnaires will be developed; behavioral checklists will be identified. Data on a limited number of children and adolescents in a variety of programs will be collected in the first year. In subsequent years, this number will grow, with the goal of establishing a statewide client outcome monitoring system.

Process Evaluation Component

While there seems to be a general consensus that the interagency teams and their coordination and collaboration are effective, no substantive evaluation processes have been initiated. Vermont CASSP and other stakeholders have invested time, energy and money to develop the interagency team network. More detailed information on its success in real-life situations is needed.

The process evaluation component will design and implement an interagency process evaluation system in Vermont. Coordination and collaboration in system planning, resource use, and individual case planning will be addressed at both the state and local levels. An interagency process evaluation will allow DMH to track important changes in the interagency management of the system of care over time.

Evaluation mechanisms, whether in-house management information and quality assurance systems, external monitors, such as planning councils, state-university partnerships, or a combination of these, help to ensure that planning is an ongoing process and that the plan itself is dynamic, rather than static. By providing feedback to those involved in implementation and planning, evaluation serves to keep both accountable agents and key stakeholders invested and on track.

REFERENCES

Behar, L. (1985). Changing Patterns of State Responsibility: A Case Study of North Carolina. *Journal of Clinical Child Psychology,* 14:188-195.

Behar, L., Holland, J. and Macbeth, G. (1987). *Distribution of Mental Health Service Components and Their Costs within a Comprehensive System for Children and Adolescents: The North Carolina Plan.* (Unpublished manuscript.)

Burchard, J. and Clarke R. (1990). The Role of Individualized Care in a Service Delivery System for Children and Adolescents with Severely Maladjusted Behavior. *Journal of Mental Health Administration,* Vol. 17, 48-60.

Friedman, R. (1987). *Service Capacity in a Balanced System of Services for Seriously Emotionally Disturbed Children.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Epidemiology and Policy Analysis, Florida Mental Health Institute, University of South Florida.

Friesen, B. and Koroloff, N. (Spring, 1990). Family-Centered Services: Implications for Mental Health Administration and Research. *Journal of Mental Health Administration,* Vol. 17, No. 1.

Gould, M., Wunsch-Hitzig, R. and Dohrenwend, B.P. (1980). Formulation of Hypotheses about the Prevalence, Treatment and Prognostic Significance of Psychiatric Disorders in Children in the United States. *Mental Illness in the United States.* Dohrenwend, B.P., Dohrenwend, B.S., Gould, M., Link, B., Neugebauer, R. and Wunsch-Hitzig, R., Eds. New York: Praeger.

Isaacs, M. (1984). *A Technical Assistance Package for the Child and Adolescent Service System Program, Volume 1.* Rockville, MD: Office of State and Community Liaison, National Institute of Mental Health, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services.

Kessler, R. (1988). A Critical Evaluation of Mental Health Needs Assessment. *Needs Assessment: Its Future,* Series BN #8. Chpt. 9, 95-100, Goldsmith, H., Lin, E., Bell, R. and Jackson, D., Eds. Rockville, MD: Division of Biometry and Applied Sciences, National Institute of Mental Health, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services.

Knitzer, J. (1982). *Unclaimed Children.* Washington, DC: Children's Defense Fund.

National Institute of Mental Health. (June, 1991). *Guidelines for State Submissions for September 30, 1991 Under Public Law 99-660 "The State Comprehensive Mental Health Services Plan Act of 1986" and Public Law 101-639 "Mental Health Amendments of 1990".* Rockville, MD: State Mental Health Planning Program, System Development and Planning Section, System Development and Community Support Branch, Division of Applied and Services Research, National Institute of Mental Health.

National Institute of Mental Health. (October, 1987). *Toward a Model Plan for a Comprehensive, Community-Based Mental Health System.* Rockville, MD: Division of Education and Service System Liaison, National Institute of Mental Health.

National Mental Health Association. (1989). *Invisible Children Project: Final Report and Recommendations.* Alexandria, VA: National Mental Health Association.

Pires, S. (1990). *Sizing Components of Care: An Approach to Determining the Size and Cost of Service Components in a System of Care for Children and Adolescents with Serious Emotional Disturbance.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Saxe, L. (1988). A Modicum of Knowledge is Sufficient. *Children's Mental Health Services and Policy: Building a Research Base.* Greenbaum, P., Friedman, R., Duchnowski, A., Kutash, K., Silver, S., Eds. Tampa, FL: Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida.

Saxe, L., Cross, T., Silverman, N. and Batchelor, W., with Dougherty, D. (1986). *Children's Mental Health: Problems and Services.* Durham, NC: Duke University Press. (Original work published 1987 by the Office of Technology Assessment, U.S. Congress; OTA-BP-H-33; Washington, DC: Government Printing Office.)

Stroul, B. and Friedman, R. (1986). *A System of Care for Severely Emotionally Disturbed Children and Youth.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

APPENDIX A

P.L. 99-660 TECHNICAL ASSISTANCE MATERIALS

Available from the State Mental Health Planning Program, National Institute of Mental Health. Contact: Lara St. John, (301) 443-4267.

1. The National Technical Assistance Center for Mental Health Planning – The First Three Years: Final Report (1987 - 1990).

    - Mary Anne Fleetwood
    - Robert K. Yin
    - Michele Teitelbaum
    - Shawn Wiley
    - March 1991

2. The National Technical Assistance Center for Mental Health Planning – States' Psychiatric Hospitalization

    - David Goodrick, Ph.D.
    - December 18, 1990

3. National Technical Assistance Center for Mental Health Planning – States' Experiences in Reducing Hospitalization

    - David Goodrick, Ph.D.
    - December 18, 1990

4. National Technical Assistance Center for Mental Health Planning – State's Implementation of P.L. 99-660: Planning and Monitoring Guide

    - Robert K. Yin
    - June 30, 1990

5. Designing Evaluation Methods to Assess the Implementation and Impact of P.L. 99-660: Stakeholder Perspectives

    - David Goodrick
    - Joann Hill
    - Noel A. Mazade
    - E. Clarke Ross
    - September 1989

6. Involving Constituents in Mental Health Planning: A Resource Guide for State Planners

   - Marjorie A. Rosenweig
   - Peter K. Vaslow
   - May 1989

7. Choices in Case Management – A Review of Current Knowledge and Practice for Mental Health Programs

   - Gail K. Robinson, Ph.D.
   - Gail Toff Bergman, M.A.
   - Leslie J. Scallet, J.D.
   - March 1989

8. Proceeding of Conference on Development State Mental Health Plans Pursuant to Public Law 99-660

   - National Institute of Mental Health --
     Division of Education and Service Systems Liaison
   - March 20-21, 1989

9. Technical Assistance Document: "Guidelines for Planning and Implementing Case Management Systems, P.L. 99-660, Title V"

   - James W. Stockdill
   - March 9, 1989

10. Guidelines for Data to Support State Mental Health Planning Under Public Law 99-660

    - Edna Kamis-Gould, Ph.D.
    - December 1988

11. Vermont Case Study – Creating the Next Generation of State Mental Health Systems

    - David Goodrick, Ph.D.
    - Rhonda Leach Schaff, M.P.A.
    - December 1988

12. Financing Community Services for Persons with Severe and Disabling Mental Illness: A Technical Assistance Manual

    - Thomas R. Vischi
    - June 1988

13. Kent County, Rhode Island Case Study: Creating the Next Generation of Comprehensive Community-Based Mental Health Service Systems

    - David Goodrick, Ph.D.
    - May 1988

14. Dane County, Wisconsin Case Study: Pioneer in Creating Comprehensive Community-Based Mental Health Services

    - David Goodrick, Ph.D.
    - May 1988

15. Ohio Case Study: From an Inpatient to a Community-Based Foundation

    - Rhonda Leach Schaff, M.P.A.
    - David Goodrick, Ph.D.
    - May 1988

16. Planning to Improve and Expand Comprehensive Community-Based Mental Health Service Systems: A Synthesis of State Efforts

    - David Goodrick, Ph.D.
    - February 29, 1987

17. Protection and Advocacy Systems for People Receiving Mental Health Services

    - Leslie J. Scallet, J.D.
    - May 16, 1986